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Notice of Independent Review Decision

DATE OF REVIEW: NOVEMBER 27, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

360-degree L3-S1 spinal surgery

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR
OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Board Certified Orthopaedic Surgeon

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Overturned (Disagree)

Medical documentation supports the medical necessity of the 360-degree L3-S1 spinal surgery.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Group:

- Office notes (02/20/07 – 10/08/07)
- Radiodiagnostics (06/18/07 – 10/05/07)
- Procedure notes (02/20/07)
- Electrodiagnostic studies (05/18/07)
- Utilization reviews (10/11/07 – 11/05/07)

M.D.:

- Office notes (02/20/07 – 10/08/07)
- Radiodiagnostics (06/18/07 – 10/05/07)
- Procedure notes (02/20/07)
- Electrodiagnostic studies (05/18/07)

D.C.:

- Clinic notes (04/20/06 – 10/25/07)
- Radiodiagnostics (04/18/06)
- Electrodiagnostics (05/02/06)
- Procedure notes (05/16/06)

ODG guidelines have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx-year-old patient who injured his lower back on xx/xx/xx . He was carrying a heavy drawer up some steep stairs. While doing so, he felt a pop in his back and he let out a scream.

On April 18, 2006, magnetic resonance imaging (MRI) of the lumbar spine in revealed desiccation at L3-L4, L4-L5, and L5-S1; 3-mm herniation at L3-L4 with an annular tear and facet overgrowth causing 9-mm canal stenosis; 4-mm herniation at L4-L5 with facet arthropathy and some canal stenosis; and right-sided 5-mm herniation at L5-S1 causing foraminal stenosis on the right, left-sided foraminal narrowing, and displacement of the right S1 nerve root.

The patient underwent passive therapy with D.C. , M.D., noted that the patient had a hyperflexed bearing at all times, a severely positive straight leg raising (SLR) test bilaterally, and right foot-drop. He administered an injection of Decadron. Electromyography/nerve conduction velocity (EMG/NCV) study of the lower extremities showed no abnormality. The patient had a partial response to caudal epidural steroid injection (ESI).

On May 16, 2006, he underwent total laminectomy and foraminotomy at L5-S1. Postoperative medications prescribed by Dr. included OxyContin and Neurontin. From May through December, the patient attended 16 sessions of active therapy. , D.O., prescribed Elavil and recommended counseling for severe anxiety and depression. Other medications included Neurontin, Flexeril, Darvocet, and tramadol. , M.D., treated him with Cialis, Yocon, and Levitra for erectile dysfunction.

2007: On January 8, 2007, , M.S., L.P.C., diagnosed chronic pain syndrome. She noted that the patient had attended 11 sessions of individual psychotherapy, while 30 sessions of a chronic pain management program (CPMP) had been authorized. From January 8, 2007, through October 25, 2007, the patient had 16 visits of therapy with Dr. On February 20, 2007, , M.D., noted the following: *In May 2006, MRI of the lumbar spine showed: (a) Significant right-sided posterolateral disc protrusion of 4-6 mm at L5-S1 deviating the right S1 nerve root posteriorly with overall central canal stenosis, facet arthrosis, and moderate bilateral foraminal stenosis; marked straightening of the lumbar lordosis with muscle spasms; and discogenic and spondylotic changes at L3-L4, L4-L5, and L5-S1 producing areas of central canal and foraminal stenosis with central canal stenosis being the most prominent at L5-S1 with a superimposed disc herniation deviating the right S1 nerve root. In August 2006, myelogram with post-*

myelogram computerized tomography (CT) demonstrated right posterolateral protrusion at L5-S1, possibly due to some fibrosis at approximately the right S1 nerve root; central canal stenosis at L4-L5 and L5-S1; and a broad-based disc bulge at L3-L4 resulting in central canal stenosis. The patient had been treated with very little passive modalities and a transcutaneous electrical nerve stimulation (TENS) unit that had not been effective. He had no active PT.

On February 20, 2007, Dr. performed redo discectomy at L5-S1 with decompression of the spinal stenosis at L3-L4 and L4-L5 via central laminectomies without fusion. Postoperatively, Neurontin, Medrol Dosepak and hydrocodone were prescribed.

In May 2007, electromyography/nerve conduction velocity (EMG/NCV) study was suggestive of a subacute/chronic left L5-S1 radiculopathy.

In June, MRI of the lumbar spine showed: (a) Status post bilateral laminectomies of L4 and L5 with satisfactory alignment; (b) enhancing fibrosis at L5-S1 along the right lateral recess contracting the right S1 nerve root; (c) posterior annular fissures at L3-L4 and L4-L5, stable; and mild-to-moderate bilateral neural foraminal stenosis at L5-S1, stable. Dr. diagnosed enuresis, urinary retention, neurogenic impotence, and voiding dysfunction. He prescribed Tofranil and Enablex.

In August, the patient returned to Dr. reporting inability to sit for any reasonable amount of time. The patient was performing exercises at home and was attempting to quit smoking. He was in the process of being weaned off hydrocodone and a couple of other physicians prescribed Paxil, Flomax, and imipramine. Dr. prescribed Chantix.

A lumbar discogram in October showed: (a) Diffuse anterior and posterior fissuring at L5-S1; (b) posterior fissuring at L3-L4 with partially concordant and severe pain in the low mid back radiating down the right calf; and (c) posterior fissure with extravasation at L4-L5 with severe concordant pain. Post-discogram CT demonstrated: (a) Grade V midline posterior annular fissure at L4-L5 with diffuse epidural extravasation; (b) midline focal grade III posterior fissure at L3-L4; (c) diffuse circumferential grade IV anterior and posterior annular fissuring at L5-S1; and (d) evidence of previous laminectomies from L4 through S1. Dr. decided to proceed with surgery.

On October 11, 2007, a request for anterior interbody fusion at L3-S1; retroperitoneal exposure and discectomy at L3-S1; anterior interbody fixation at L3-S1; posterior decompression at L5-S1; transverse process fusion at L3-S1; posterior internal fixation at L3-S1; allograft bone graft; autograft in situ bone graft; autograft iliac crest bone graft; bone marrow aspirate with an anticipated length of stay 2-3 days was denied as not medically necessary. Rationale: *The procedure, considering the information available for review, is not medically indicated, reasonable, or necessary. The compensability of causal relationship*

of some or all of this claim is currently in dispute, subject to determination by the claims department or the Division of Workers Compensation.

On October 15, 2007, the denial was upheld with the following rationale: This xx-year-old man's neurological examination is normal and he has no documented instability. Surgery appears to be recommended based purely on the results of discography and a subjective test subjective to a significant percentage of false positives, especially in previously operated discs. His multilevel discogenic disease places him in a poor prognostic category for recovery. In addition, the stage would be set for late term complications that would make him worse than he is now. Request for a lumbar fusion is not reasonable or medically necessary with the available information.

An appeal for the denial was made; however, on November 5, 2007, the denial was upheld stating: The ODG criteria note that all physical medicine and manual therapy interventions are completed, which is not the case with this patient. All pain generators are identified and treated. X-rays demonstrate spinal instability on myelogram, CT or discography and MRI demonstrating disc pathology, which does appear to be the case. Spine pathology limited activity level, which is not the case. From the review of the medical records, the patient does not appear to have had all physical medicine and manual therapy intervention tried and this is a 3-level fusion which the ODG does not support. Therefore, at this time the request is not medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Mr. has had a long complicated course with multiple surgeries performed on his lumbar spine. He has radiographic as well as physical examination findings consistent with continued discogenic and mechanical low back pain and has undergone psychosocial evaluation. Mr. has attempted, and failed, extensive physical therapy and chiropractic care at this time. Due to the extensive failure of conservative and well as surgical treatment of his lumbar spine, he is a candidate for further surgical treatment to include 360-degree L3-S1 spinal surgery in an attempt to alleviate his mechanical low back pain.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES