MATUTECH, INC.

PO Box 310069
New Braunfels, TX 78131
Phone: 800-929-9078
Fax: 800-570-9544

Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 15, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
360-degree L5-S1 fusion surgery and Cybertech TLSO back brace

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

REVIEW OUTCOME

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

X Upheld (Agree)

Medical documentation does not support the medical necessity of 360-degree L5-S1 fusion surgery and Cybertech TLSO back brace

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Texas Department of Insurance

- Utilization reviews (12/28/07 – 01/10/08)

- Office notes (08/09/06 - 12/19/07)
- Radiodiagnostics (06/10/05 - 10/31/07)
- Lumbar ESI (04/06/06)
- Utilization reviews (12/28/07 – 01/10/08)

D.C.

- Office notes (11/03/04 – 12/07/07)
- Therapy (11/03/04 – 10/04/05)
- Radiodiagnostics (06/10/05 – 05/03/07)
- Lumbar ESI (04/06/06)
- Review by IRO (08/20/07)

M.D.

- Office notes (08/09/06 - 12/19/07)
- Lumbar ESI (04/06/06)
- Radiodiagnostic (06/10/07 - 10/31/07)

- Therapy (11/03/04 – 04/10/07)
- Office notes (02/08/06 – 12/07/07)
- Radiodiagnostics (06/10/05 – 10/31/07)
- Lumbar ESI (04/05/06)

ODG AND ACOEM guidelines have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was injured. She was weighing a patient when the patient started to fall; she tried to hold him and heard a pop in her back.

Following the injury, D.C., assessed lumbago, lumbosacral sprain/strain, and cervicogenic headaches; placed the patient off work; and treated her with chiropractic therapy. The patient improved temporarily but had recurrence of complaints for which Dr. treated her with additional chiropractic therapy and kept her off work.

Magnetic resonance imaging (MRI) of the thoracic spine revealed minimal non-compressive protrusions in the mid thoracic spine. MRI of the lumbar spine revealed mild facet hypertrophic changes at L3-L4 and L4-L5 and mild facet arthropathy at L5-S1.

M.D., a pain specialist, assessed chronic intractable back pain and possible facet syndrome. He performed a lumbar epidural steroid injection (ESI) and treated the patient with medications (Naprelan, Medrol Dosepak, Soma, Neurontin, and Zanaflex).

M.D., a neurosurgeon, noted the x-rays revealed some mild disc space narrowing at L5-S1. He recommended supervised exercises. D.C., a designated doctor, assessed maximum medical improvement (MMI) as of September 26, 2006, and assigned 5% whole person impairment (WPI) rating. Towards the end of 2006, the patient attended 12 sessions of physical therapy (PT). However, she had no improvement in back pain.

A repeat lumbar MRI in May 2007 revealed: (1) Minimum degree of spondylosis throughout the spine. (2) A lateral disc bulge at L5-S1 on the right slightly touching the S1 nerve root at the neural foraminal level with hypertrophy of the facet joint along with early disc desiccation. (3) A broad-based bulging disc at L4-L5 on the left slightly touching the exiting nerve root; bilateral foraminal stenosis minimally due to hypertrophy of the facet joints.

A lumbar discogram obtained in October 2007 was positive for concordant pain at L5-S1. Postdiscogram computerized tomography (CT) revealed some

degenerative facet changes at L5-S1 with a possible posterior central annular tear. Per Dr. the discogram showed strong provocation at L5-S1 with concordance for low back and lower extremity pain.

On December 19, 2007, Dr. reviewed CT-discogram findings. The patient complained of low back pain and right lower extremity pain ranging from 7-9/10. On examination, there was decreased ROM of the lumbar spine. Extension and rotation was positive bilaterally, left greater than right, with pain provocation in the low back on the ipsilateral side of testing. There was tenderness over the paraspinal muscles bilaterally. SLR test was positive on the right with pain radiating to the knee posteriorly. Dermatomal pattern was numb at the right proximal thigh and the dorsum of the right foot representing L2 and L5 nerve root distributions. Dr. diagnosed disc resorption at L5-S1; facet arthrosis at L5-S1; discogenic pain at L5-S1; lumbar radicular syndrome, and recommended a 360-degree fusion and instrumentation at L5-S1.

On December 28, 2007, the request for 360-degree fusion at L5-S1 was non-certified. Rationale: *Based on review of the medical records provided and evidence-based medicine at this juncture, without the benefit of peer discussion with Dr. I cannot recommend the surgery as medically reasonable or indicated based on the fact that there is no evidence of motion segment instability at the L5-S1 junction. Clearly, this is a young lady with significant subjective complaints of low back pain and psychological overlay in the form of depression associated with this, which raises concerns for response to surgical outcome.*

On January 10, 2008, a request for reconsideration of 360-degree lumbar fusion was non-certified with the following rationale: *Within the medical reports made available for review, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which fusion is indicated (such as instability), and imaging demonstrating anteroposterior motion of one vertebra over another that is greater than 4.5 mm in the lumbar spine, evidence-based guideline criteria (ACOEM, Official Disability Guidelines) necessary to support the medical necessity of the requested anterior/posterior lumbar fusion with three inpatient days.*

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

THERE ARE NO OBJECTIVE FINDINGS SUPPORTING THE NEED FOR 360 SPINAL FUSION AT THIS TIME. WHILE LUMBAR SPONDYLOSIS WITH PAIN, WHICH HAS FAILED TO IMPROVE WITH EXTENDED CONSERVATIVE MEASURES IS EVIDENT, THERE IS NO INSTABILITY WHICH WOULD SUPPORT THE ADDITION OF AN ANTERIOR PROCEDURE. PER OFFICIAL DISABILITY GUIDELINES, 360 SPINAL FUSION IS NOT INDICATED IN THIS PATIENT.

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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES