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Notice of Independent Review Decision

DATE OF REVIEW: July 14, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4-L5 laminectomy, foraminotomy, discectomy, PLIF with unilateral and autograft L4-S1, posterior spinal fusion with right iliac crest bone graft and internal fixation with IP 3 day LOS (21630)

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

Diplomate, American Board of Neurological Surgery

REVIEW OUTCOME

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

Upheld (Agree)

Medical documentation does not support the medical necessity of L4-L5 laminectomy, foraminotomy, discectomy, PLIF with unilateral and autograft L4-S1, posterior spinal fusion with right iliac crest bone graft and internal fixation with IP 3 day LOS (21630)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Texas Department of Insurance

- Utilization reviews (05/22/08 and 06/12/08)

M.D.

- Office notes (10/12/05 - 05/09/08)
- Radiodiagnostics (09/28/05 – 04/22/08)
- Lumbar ESIs (12/15/05 - 01/26/06)
- Utilization reviews (05/22/08 and 06/12/08)

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Office notes (01/11/07 - 06/23/08)

ODG has been utilized for denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old male who was injured on xx/xx/xx. He developed right-sided low back pain after a hard landing of the flight.

PRE-INJURY RECORDS: On xx/xx/xx, the patient injured his low back when some luggage fell onto his low back. Magnetic resonance imaging (MRI) revealed mild posterior protrusions from L1-L2 through L3-L4, moderate-sized posterior protrusions at L4-L5 and L5-S1, right posterolateral annular tear at L4-L5, and moderate bilateral foraminal narrowing at L4-L5. He underwent a series of three lumbar epidural steroid injections (ESIs) with excellent response and returned to work in February 2006.

POST-INJURY RECORDS

2007: M.D., saw the patient for low back pain and right leg pain with numbness/tingling. Straight leg raise (SLR) test was positive on the right. X-rays were negative. Dr. assessed bilateral lumbar intervertebral disc disease, prescribed Flexeril and Medrol Dosepak, and released him to regular duty.

MRI of the lumbar spine revealed: (1) Disc desiccation at L1-L2 with a mild disc bulge producing mild mass effect on the thecal sac. (2) Mild broad-based disc protrusion at L2-L3 producing mild mass effect on the thecal sac. (3) Mild broad-based disc protrusion at L3-L4 producing mild mass effect on the thecal sac. Bilateral facet arthrosis and ligamentum flavum hypertrophy was noted with mild spinal canal stenosis and mild bilateral neuroforaminal narrowing. (4) Disc desiccation at L4-L5 with a mild disc bulge producing mild mass effect on the thecal sac. Bilateral facet arthrosis and ligamentum flavum hypertrophy was noted with mild spinal canal stenosis and mild-to-moderate bilateral neuroforaminal narrowing. A high intensity zone was present, which might represent an annular fissure or tear. (5) Disc desiccation at L5-S1 with a disc bulge demonstrating a moderate central protrusion producing mild mass effect on the thecal sac. Bilateral facet arthrosis and mild bilateral neuroforaminal narrowing was seen.

Dr. assessed clinical maximum medical improvement (MMI) as of May 9, 2007, and assigned 0% whole person impairment (WPI) rating.

2008: In April, a lumbar MRI was obtained, which revealed: (1) Mild circumferential disc bulge at L1-L2 mildly impressing the thecal sac. (2) Mild broad-based disc protrusions at L3-L4 and L4-L5 mildly impressing on the thecal sac with bilateral facet arthrosis and mild-to-moderate bilateral neuroforaminal narrowing. Ligamentum flavum hypertrophy and mild spinal canal stenosis was seen at L4-L5. (4) Mild circumferential disc bulge at L4-L5 mildly impressing on the thecal sac with bilateral facet arthrosis and mild bilateral neural foraminal narrowing. (5) Loss of lordosis possibly due to myospasms.

Dr. rescinded the date of MMI as the patient had re-aggravated his back and had returned for treatment.

M.D., a spine surgeon, noted that the patient had undergone three lumbar ESIs in 2007 followed by PT, which relieved his pain. The present complaints were tingling in the toes, weakness in the legs, and disturbed sleep. Examination showed diminished sensation in the S1 dermatome and mildly positive right sitting root test. X-rays revealed moderate disc space narrowing at L4-L5 and severe disc space narrowing at L5-S1 with anterior traction spur formation. Dr. assessed L4-L5 and L5-S1 herniated nucleus pulposus (HNP) and right S1 radiculopathy. He reviewed the MRI and recommended L4-L5 laminectomy, foraminotomy, discectomy, and posterior lumbar interbody fusion (PLIF) at L4-L5.

On May 22, 2008, M.D., denied the request for the surgery with the following rationale: *“X-rays demonstrated degenerative changes. MRI also demonstrated degenerative changes, 4-mm protrusion at T12-L1, 3-mm protrusion at L3-L4, 4.5-mm protrusion at L4-L5, and 5-6 mm protrusion at L5-S1. Flexion/extension studies on September 28, 2006, do not report any instability. Claimant can reportedly stand on toes, but unable to stand on heels on sustained heel stance. Claimant does have decreased sensation on the S1 dermatome site is not identified. Reflexes are symmetric. Claimant has multilevel degenerative disc disease (DDD) essentially affecting entire lumbar spine, however, no instability shown on any study that would lead to the need for fusion. The request is not indicated. Per ODG, there was limited scientific evidence about the long-term effectiveness of fusion for DDD compared with natural history, placebo or conservative treatment.”*

Request for the lumbosacral orthosis in conjunction with the spinal surgery was denied as ODG did not support the postoperative use of brace.

On June 12, 2008, M.D., denied the appeal for fusion surgery with the following rationale: *“The claimant complains of low back pain and pain in the legs and groin with numbness at the knees. MRI notes a left paracentral disc herniation at L4-L5 with an inferior sequestered fragment, moderate spinal stenosis, and foraminal stenosis. At L5-S1, there are Modic changes and foraminal stenosis bilaterally. There is a disc protrusion at L2-L3, L3-L4, and L4-L5 as well. The claimant has received prior care including lumbar ESIs. Objective exam reveals a limp and instability to stand on his heels in a sustained fashion. There is decreased sensation in an S1 dermatome and a mildly positive straight leg raise (SLR). The claimant has multilevel disc disease. Provider has recommend surgery. Based on the information provided, without the opportunity to speak with the provider, the requested fusion is not supported at this time.”*

On June 23, 2008, Dr. noted that the patient's complaints were the same. She refilled Flexeril and Ultracet and recommended modified duty.

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

Medical material reviewed and listed numerically included:

1. Lumbar MRI report of 9/25/2005 by, M.D.
2. Pain management note by, 10/12/2005

3. 12/15 operative report regarding epidural steroid injections by , M.D.
4. Lumbar MRI report 1/23/2007 by
5. Lumbar MRI report 1/28/2008 by, M.D.
6. 5/8/2008 history and physical report by, M.D., and also a note on 5/9/2008 by the same doctor
7. Corporation report of 5/22/2008 denying lumbar laminectomy and fusion and a similar note on 6/12/2008

This case involves a now xx year old male who on xx/xx/xx was reaching up to a passengers bag when the bag fell striking him in the low back. He had immediate low back pain. Physical therapy was not beneficial so pain management consultation recommend epidural steroid injections which were carried out on 10/12/2005. 30% relief was obtained and this led to repeat injections on 12/15/2005 and 1/26/2006. These helped to the point that the patient was able to return to work. On xx/xx/xx, secondary to a hard landing in an airplane, the patient had his low back pain return with lower extremity pain. On examination there were no neurologic deficits. Straight leg raising is positive bilaterally. A 1/23/2007 lumbar MRI showed multiple levels of chronic change without significantly surgically correctable pathology. Another MRI on 4/22/2008 showed essentially the same changes again without distinct surgical pathology being suggested. A stand up MRI with flexion and extension views was done at one time, but the report does not indicate whether or not there was instability but subsequent examiners have indicated that these films did not show any evidence of instability.

I agree with the denial for the proposed operative procedure. There is no demonstration of instability at any particular joint that might be fused. In addition, there is nothing on examination or testing to show a specific nerve root or nerve roots that upon decompression would be helpful in relieving symptoms. Therefore there is a good chance that the proposed operative procedure including fusion at the lower level would not diminish pressure on the nerve root that is involved and is causing his lower extremity symptoms. As far as his back pain is concerned, there are changes at multiple levels in the lumbar spine that could account for that problem. More testing such as lumbar CT myelogram with flexion and extension views may change my opinion but at the present time from the material that I have reviewed, I agree with the denial for the proposed operative procedure.

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

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**