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Notice of Independent Review Decision

DATE OF REVIEW: May 13, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

A 360-degree fusion spinal surgery from L3 through L5, with LOS 2-3 days

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

The physician providing this review is a spinal neurosurgeon. The reviewer is national board certified in neurological surgery. The reviewer is a member of the American Association of Neurological Surgeons, The Congress of Neurological Surgeons, The Texas Medical Association, and The American Medical Association. The reviewer has been in active practice for 38 years.

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 a 360-degree fusion spinal surgery from L3 through L5, with LOS 2-3 days in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office notes (03/19/07 – 03/19/08)
- Diagnostic studies (03/30/07)
- Utilization review (03/31/08 & 04/08/08)

Spine Care:

- Office notes (03/14/07 – 03/19/08)
- Diagnostic studies (11/24/07 - 03/30/07)

ODG criteria have been used for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old male who injured his lower back on xx/xx/xx, while helping an employee break up cement with a jackhammer.

In November 2004, magnetic resonance imaging (MRI) of the lumbar spine revealed postoperative changes at L4-L5 posteriorly and mild disc bulges at L3-L4 and L4-L5 with neural foraminal narrowing most prominent on the right at L4-L5.

In 2007, , M.D., evaluated the patient for persistent back and bilateral leg pain. The treatment history was obtained as follows: *In October 2001, MRI of the lumbar spine indicated decreased height and signal intensity at L3-L4, a central bulge and herniated nucleus pulposus (HNP) centrally and to the right at L4-L5 compressing the right L5 nerve root with bilateral foraminal narrowing and central stenosis, right side greater than the left. Lumbar discography elicited severe concordant pain at L4-L5 and demonstrated a posterior fissure at L3-L4. On February 18, 2002, the patient underwent laminectomy at L4-L5. He was declared at statutory maximum medical improvement (MMI) on May 1, 2002, with 19% impairment rating (IR). In January 2003, MRI revealed central and right-sided disc protrusion at L3-L4; central and right-sided disc protrusion at L4-L5 and L5-S1 with central stenosis and slight impingement of the right S1 nerve root. X-rays in February 2007 indicated considerable degenerative disc disease (DDD) at L5-S1 and to a lesser extent at L2-L3 and L3-L4 with considerable scoliosis of the upper lumbar region. Electrodiagnostic studies in 2002 indicated evidence of left L5 radiculopathy. The patient had interventional blocks in the past, which were not of much benefit. The patient continued to have unremitting back pain radiating down the legs associated with numbness and tingling. His right leg symptoms were more significant than the left. He was utilizing hydrocodone, Neurontin, Soma, and ibuprofen. Dr. noted markedly decreased range of motion (ROM) of the lumbar spine with decreased motor strength of left extensor hallucis longus (EHL). A discography was ordered, which was denied and an IRO decision in July 2007 upheld the prior adverse determination of the discography. Eventually, Dr. requested a two-level 360 degree fusion.*

In March 2008, a psychological evaluation was accomplished and the patient was felt to be an excellent surgical candidate.

On March 31, 2008, utilization review for the 360 degree lumbar fusion from L3 through L5 was denied with the following rationale: *Based on the clinical information available, there is no compelling indication for spinal fusion at this juncture. While I would clearly acknowledge that this gentleman has failed in his original surgical procedure and that he continues to have ongoing complaints of back pain, there are no clear signs of demonstrable instability and no signs of progressive neurologic deficits and/or profound radicular leg pain. Furthermore, while it appears as though it would be reasonable to anticipate surgical fusion at L4-L5 as a result of a wide decompression, it is unclear as to the indications to include L3-L4 in the fusion. Furthermore, it appears that a preponderance of this gentleman's pain complaints are in his back, and it is unclear as to whether or not he has sufficient leg pain to warrant surgical decompression, which appears to have been the primary indicator for surgical fusion as a result of a risk iatrogenic instability. These issues cannot be addressed within the records as provided and thus when ODG criteria is reviewed in conjunction with the records*

available, the surgery can neither be recommended as either reasonable or medically necessary.

On April 8, 2008, the appeal for the proposed lumbar fusion surgery was denied with the following rationale: *Recent, high quality studies on discography have significantly questioned the use of discography results as a key operative indication for either intradiscal electrothermal therapy (IDET) or spinal fusion. Records do not reflect instability, fracture, or other criteria under current guidelines to support fusion. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, the request is not indicated.*

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

Medical material reviewed listed numerically included:

1. Clinical history with summary of events by Incorporated
2. Lumbar MRI report 11/24/04 by, M.D. and 3/30/07 by, M.D.
3. Chart notes by, M.D. 3/14/07, 5/24/07, 6/6/07, 3/19/08
4. Insurance Company's utilization review decision of 3/31/08
5. Workers Compensation Service notification of decision on 4/8/08 by M.D.
6. Notes by, M.D., Ph.D., on 3/19/07, 12/17/07 and 3/17/08
7. Notes by, M.D., a pain management specialist on 6/6/07 and 11/30/07
8. Psychological evaluation on 3/13/08 by, Ph.D., a psychologist

This case involves a now xx year old male who on xx/xx/xx was breaking up concrete with a jack hammer and developed low back pain. This back pain persisted despite conservative measures and continued pain with an MRI showing difficulty at the L4-5 level led to a 2/18/02 L4-5 lumbar laminectomy with some relief of symptoms. Symptoms have however intermittently been severe in the form of low back and lower extremity discomfort primarily on the right side. This has persisted despite the considerable medications including muscle relaxants, anti-inflammatories and pain medicines. The patient's last MRI of the lumbar spine on 3/30/07 showed probable recurrent disc herniation at the L4-5 level on the right side with nerve pressure. There are also changes less severe at the L3-4 and L5-S1 levels without definite nerve pressure. There was a question of a synovial cyst being present contributing to the nerve compression by one of the reviewers. The patient stated to one of the reviewers that he had a CT myelogram in November 2004, but no record of that is available to review. Discography has been denied by the insurance carrier. The last recommendation by a treating physician has been for an L3-4 and L4-5 total discectomy with interbody fusion.

I agree with the denial for the proposed procedure. There are no imagining studies suggesting instability or none definitely showing nerve root compression at the L3-4 level, a much less invasive re-operation at the L4-5 level with removal of possible disc herniation or even synovial cyst maybe as beneficial as the more extensive proposed procedure. CT myelography with flexion and extension views may suggest more in the way of nerve pressure at both the proposed operative levels and may change this reviewer's opinion but with the material

made available for this present review that does not indicate that the recommended two level fusion with laminectomy is indicated.

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

Guidelines developed by the reviewer over 38 years of evaluating spinal surgical problems.

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES