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Notice of Independent Review Decision

DATE OF REVIEW: February 9, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient lumbar laminectomy with fusion, 1 day LOS and TLSO brace

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

Certified, American Board of Orthopaedic 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 the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

M.D.

Office visits (09/14/06 – 01/05/09)
Radiodiagnostic tests (09/26/06 – 07/16/07)
Procedure Notes (11/28/06 - 04/04/07)

Utilization reviews (12/22/08 and 01/15/09)
Radiodiagnostic tests (04/04/05 – 11/17/06)
Electrodiagnostic study (10/11/05)
Office Notes (10/12/06 – 01/05/09)
Procedure Notes (11/28/06)

ODG Criteria have been used for denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx-year-old male who was injured on xx/xx/xx, when he was working on a basket at 16' high and the basket flipped over and fell on him. He developed pain in his neck, mid back, and lower back.

On April 4, 2005, the patient was investigated at for crush injury to T4-T5. Magnetic resonance imaging (MRI) of the entire spine revealed: (1) Mild

compression fracture at C7 and possible ligamentous injury to the C7-T1 interspinous ligament. (2) Compression fracture of the T1-T5 vertebral bodies and burst fracture of T4 with mild retropulsion and retropulsed fragments contacting the anterior cord. (3) Interspinous ligamentous injury from C7-T1 to T4-T5. (4) Abnormal signal and contour related to known sacral fractures, subcutaneous hematoma over the sacrum likely related to sacral fractures. (5) Two epidural hematomas, one at L4 and the other at L5, indenting the left posterolateral aspect of the thecal sac.

In October 2005, electromyography/nerve conduction velocity (EMG/NCV) and dermatomal somatosensory evoked potential (DSEP) study of the upper and lower extremities were essentially unremarkable.

In August 2006, MRI of the lumbar spine revealed diffuse disc bulge at L3-L4 with a small left-sided intraforaminal disc herniation causing mild left foraminal stenosis and minimal mass effect on the thecal sac, minor disc bulge at L2-L3, and slight deformity of the second sacral segment consistent with an old fracture.

In September 2006, ., M.D., a neurosurgeon, evaluated the patient for persistent pain in the left anterior thigh with some numbness. He noted the following treatment history: *Following the injury, the patient developed pain in his entire back. He had open fracture of the left iliac wing that was debrided and closed. He had to have a laparotomy because of abdominal injury with partial bowel resection. He had not been able to return to work. He was treated with physical therapy (PT) and multiple steroid injections. The patient was utilizing Ultram, Skelaxin, Darvocet, and Lidoderm patches.* Dr. noted restricted range of motion (ROM) of the neck with paracervical muscular tightness and loss of cervical lordosis. There was diminished mobility of the lower back. The patient walked with a slightly flexed posture at the low back and had a left antalgic gait. There was tenderness over the left sciatic outlet, positive straight leg raising (SLR) on the left, depressed left knee reflexes, little weakness in the left quadriceps, and decreased sensation over the left anterior thigh. Dr. assessed left L4 radiculopathy secondary to left L3-L4 herniated disc. He obtained a lumbar myelogram that revealed mild anterior extradural defects from L3 to L4-L5 with less filling of the exiting nerve roots sleeve of L3 on the left. Post-myelogram computerized tomography (CT) scan revealed degenerative disc disease (DDD) at L3-L4, L4-L5, and L5-S1; minimal broad-based disc bulge at L3-L4 with filling of the right exiting nerve root but no filling at the left exiting nerve root sleeve within the foramen which might be due to disc bulge and impingement; mild minimal bulge at L4-L5 with mild bilateral foraminal narrowing; and mild disc bulge centrally at L5-S1 and to the left of midline.

On November 20, 2006, Dr. performed left L3-L4 laminectomy, left L3 and L4 nerve root decompression with opening of lateral recess and foraminotomies, and excision of large left lateral L3-L4 disc extrusion with decompression of L3 and L4 roots. Postoperatively, the patient had excellent relief of his left leg pain; however, his major problem was chronic posttraumatic neck pain with bilateral shoulder and arm pain. He was getting worse with increasing numbness, dysesthesias, and weakness in the arms.

In January 2007, cervical myelogram revealed central defects at C5-C6 and C6-C7 with less filling of the left nerve root sleeves from C3 through C5-C6.

Postmyelogram CT scan revealed DDD and spondylosis with findings most noted at C4-C5 and C5-C6 including severe uncinat process and facet hypertrophy on the left producing severe left foraminal narrowing and mild narrowing of the right foramen at C4-C5. There was less filling of the left exiting nerve root sleeve at C5-C6 with a broad-based disc bulge and spondylosis contacting the disc associated with mild-to-moderate narrowing of the left neural foramen due to spondylosis.

On April 4, 2007, Dr. performed anterior discectomy at C4-C5 and C5-C6 with bilateral C5 and C6 root decompression, excision of the herniated disc, and interbody fusion at C4-C5 and C5-C6. Postoperatively, the patient had good flexibility of the neck.

In May 2007, MRI of the cervical spine revealed postsurgical changes with spondylosis at C4-C5 and C5-C6, subtle added signal in the left superior neural foramen adjacent to the disc at C6-T1 possibly presenting a small focal disc protrusion producing mild-to-moderate left foraminal narrowing in conjunction with spondylosis. Dr. treated the patient with occasional Darvocet for minimal neck pain. In December 2007, he noted that patient was not having much trouble with his neck but was having some pain in the low interscapular area probably secondary to compression fractures at T4 and T5. Dr. started the patient on hydrocodone for breakthrough pain and recommended cervical epidural steroid injection (ESI). In March 2008, Dr. added Motrin and made an appeal for cervical ESI.

In November 2008, MRI of the lumbar spine with and without contrast was obtained for low back pain in the left hip and leg with some numbness and tingling and radiculopathy in both feet. The MRI revealed prior partial discectomy at L3-L4 which appeared to be in the central portion of the base. However, the left lateral aspect demonstrated a residual disc with some adjacent granulation tissue, disc bulge resulting in at least moderate neural foraminal encroachment on the left. The L4-L5 demonstrated mild neural foraminal encroachment bilaterally due to mostly disc disease, also seen on the left at L2-L3.

In December 2008, Dr. noted that since past six months, the patient had experienced increasingly severe low back pain and left leg radiating pain. He required hydrocodone, pain patches, and Darvocet. He was incapacitated by pain in the lumbar region radiating into the left hip and buttock area and down to the left leg with some numbness, dysesthesias and feeling of weakness. MRI of the pelvis had shown an old fracture of the left anterior iliac spine and right inferior pubic ramus. He apparently had sacroiliac (SI) joint steroid injections. Examination showed restricted lumbar ROM, positive reverse and regular SLR on the left, depressed left knee reflex and some weakness of the left quadriceps and left antalgic gait. Dr. discussed treatment options including medications, lumbar ESI, or surgery consisting of a posterior L3-L4 decompression, fusion and instrumentation because of the instability and the recurrent disc. The patient preferred proceeding with the surgery.

On December 22, 2008, inpatient lumbar laminectomy with fusion with one day length of service and durable medical equipment (DME) including TLSO brace was non-certified. Rationale: *"Inpatient lumbar laminectomy with fusion with one day length of stay and thoracolumbosacral orthosis is not medically indicated and*

appropriate. On November 28, 2006, a left L3-L4 laminectomy and L3-L4 root decompression and excision of the left large lateral L3-L4 disc extrusion were performed. On November 17, 2008, a lumbosacral MRI demonstrated postsurgical changes with left lower aspect of the extruded disc with some adjacent granulation tissue, disc bulge, and moderate neural foraminal encroachment upon the left. However, there had been no evidence of a progressive neurologic episode, cauda equina syndrome, or instability documented to indicate the fusion is necessary. With regarding the decompressive portion of this procedure, there has been neural compressive compromise documented on physical examination such that on December 15, 2008, there is decreased knee reflex and left quad weakness. Based upon this information; however, decompression and fusion is not warranted or indicated. As the index procedure is not medically necessary, the request for inpatient stay and TLSO brace cannot be recommended.”

On January 5, 2009, Dr. appealed the denial for the surgery: “The patient has a large disc herniation and stenosis at L3-L4 with a severe chronic mechanical low back disorder and bilateral hip and leg pain with numbness, dysesthesias and weakness in his legs. He had an unstable segment at L3-L4 and that is the reason for the fusion and instrumentation. He is incapacitated by his pain and is unable to work. He takes hydrocodone 7.5 mg.”

On January 15, 2009, the appeal for inpatient lumbar laminectomy with fusion with one day length of stay was denied with the following rationale: “The available clinical records indicates the patient sustained injury to his neck and low back as a result of work-related activity on xx/xx/xx. The submitted clinical records largely cover the patient’s cervical spine. There are only limited records regarding lumbar spine, which subsequently provides a fragmented history of treatment. Records indicate the patient has a history of a previous L3-L4 discectomy reported secondary to extruded disc herniation. The record does not include any imaging studies for this operative report. The patient is now reported to have a recurrent disc with reported lower extremity headache with symptoms that are not adequately documented in the clinical records. The record does not establish that the patient has failed all conservative care. The record further does not indicate any instability in the lumbar spine at the L3-L4 segment. Current evidence-based guidelines require all patients undergoing lumbar fusion undergo a preoperative psychiatric clearance, and the records do not suggest that this had been performed. In the absence of clinical information to establish that the patient is unstable at L3-L4, has failed conservative care, and has passed appropriate psychiatric evaluation, the requested procedure cannot be considered medically necessary at this time.”

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

This claimant presented as a xx year-old male who appears to have sustained numerous injuries to the cervical, thoracic, and lumbar axial skeleton (in addition to an open sacral injury and visceral injury) as the result of the described mechanism of injury. The current issue is directly related to the alleged injury at L3-4, its treatment, and the current complaints as part-and-parcel of naturally occurring sequelae. Although the claimant did well initially after L3-4

laminectomy and decompression in November 2006 (improved low back pain and left leg radicular symptoms consistent with the L4 nerve root), he subsequently has developed *left* leg symptoms that *may* be consistent with the L4 nerve root distribution. A repeat lumbar MRI in November 2008 (ordered by Dr. whose medical records are not available for review herewith) revealed “residual” disc material toward the left at L3-4 with associated postoperative granulation tissue, causing moderate to severe left neuroforaminal stenosis. There was no description of significant spondylolisthesis, intersegmental instability, facet joint dissociation, etc.

Although Dr. has opined the presence of instability – the ODG-approved and most medically appropriate indication for fusion – he has produced insufficient evidence of such, as there is no description or recording of instability on lateral flexion-extension x-rays. On December 15, 2008, Dr. opined the need for fusion surgery at L3-4 in a two paragraph office visit note, stating that this was the first time he had examined the patient for 9 months (having previously focused treatment on the cervical spine, not the lumbar spine from which the patient had recovered two year previously). Only two sentences out of the two paragraphs had anything to do with a clinical exam, and even then, only nerve root tension signs, reflexes, strength, and gait were examined. Despite no specific imaging evidence of L3-4 intersegmental instability (criteria published per ODG), despite no psychologic evaluation (per ODG criteria), and despite a perfunctory examination after not seeing the patient for lumbar problems since 12/21/06 (two years antecedent), the necessity of fusion at L3-4 was considered necessary – and later considered incontrovertible, per a rebuttal letter in response to the initial denial for fusion surgery. No new neurodiagnostic confirmatory studies have been obtained. No evidence herewith suggests that typical conservative management, such as an ESI, has been attempted.

For the reasons detailed above and those well-delineated by the previous reviewers, there appears to be insufficient evidence-based indication for the procedure requested, particularly the fusion, without evidence of an attempt at reasonable conservative efforts, and without imaging evidence of true anteroposterior instability per ODG criteria. As such, the denial of services requested appears to have been appropriate based on the information provided by the requestor, per established TDI-recognized evidence-based sources (ODG). The requestor made no attempt to discuss ODG criteria in either his initial request for services or in his opportunity for rebuttal.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES