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DATE OF REVIEW: May 27, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient Hybrid ADR at L4-L5 with 2 days LOS

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

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 the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work-related injury on xx-xx-xx. He was trying to lower it on two supports. The pipe fell hitting the patient on the right side of his body and then rolling down onto the lateral aspect of his right leg. This knocked him out of the way, injuring his lower back.

2007: In October, magnetic resonance imaging (MRI) of the lumbar spine revealed: (1) Moderate spinal stenosis at L4-L5 due to a 5-mm posterior disc bulge and degenerative facet hypertrophic changes contributing to mild bilateral neural foraminal narrowing. (2) Grade I anterior spondylolisthesis of L5 on S1 with suspected bilateral L5 pars fractures; a 6-mm disc bulge at the same level in addition to mild disc height loss and mild bilateral neural foraminal narrowing. (3) Minimal disc bulge at L2-L3.

2008: In December, M.D., noted the following treatment history: *Initially, the patient was seen by the company doctor who managed him conservatively for lumbar sprain/strain. The patient worked at light duty for approximately eight months. He reported having two epidural steroid injections (ESIs). He was treated with physical therapy (PT) with minor improvement. On April 14, 2008, the patient was assessed to reach maximum medical improvement (MMI) with 5% whole person impairment (WPI) rating.* Currently, the patient complained of low back, leg, and mid back pain all at about 8/10. History was positive for hypertension, anxiety, depression, and sexual difficulty. Surgical history was positive for right forearm surgery in 1990 and degenerative joint disease (DJD) of both knees. Lumbar flexion was fingertips to mid shin. Flexion was more uncomfortable than lumbar extension. The patient demonstrated slight decrease in left extensor hallucis longus (EHL) and dorsiflexors. Seated straight leg raise (SLR) increased low back pain. Dr. interpreted MRI of the lumbar spine dated October 2007, as follows: Spondylolisthesis of L5 on S1, disc desiccation at L5-S1 and at L4-L5, and mild narrowing bilaterally at L5-S1. Dr. assessed continued low back and bilateral lower extremity pain status post work-related injury on September 19, 2007. Dr. recommended lumbar myelogram with CT to clarify any compressive lesion within the lumbar spine and a two-level discogram followed by computerized tomography (CT) and bilateral lower extremity electromyography/nerve conduction velocity (EMG/NCV) study.

EMG/NCV of the lower extremities was unremarkable. Lumbar myelogram-CT scan revealed: (1) Degenerative changes of the lumbar spine most pronounced at L4-L5. (2) L5 pars defect with anterior subluxation of L5 on S1 with moderate posterior disc bulge at L5-S1 and bilateral moderate neural foraminal narrowing.

The patient underwent behavioral medicine evaluation and was diagnosed with pain disorder associated with both psychological factors and general medical condition. The evaluator recommended to continued visits for medication prescriptions and random urine toxicology screen.

2009: In March, lumbar discogram revealed positive disc provocation at L4-L5 with abnormal nucelogram and full-thickness posterior annular tear and epidural extravasation; positive disc provocation at L5-S1 with abnormal nucelogram indicative of diffuse disc degeneration and bilateral L5 pars defect with grade I spondylolisthesis. CT scan revealed: (1) grade IV annular tears at L4-L5 and L5-S1. (2) Contrast material in the ventral epidural space extending from L1-L2 through L4-L5, reflecting a partial epidural injection of contrast; however, it could also represent a high-grade tear at L4-L5 with epidural contrast extension. (3) Spondylolytic spondylolisthesis at L5-S1. (4) Transitional vertebral level at the thoracolumbar junction. Post-discogram x-rays revealed grade IV internal disc disruption at L4-L5 and L5-S1 and possible high-grade (grade 5) internal disc

disruption at L4-L5 likely reflecting contrast extending along the injection needle track.

Dr. reviewed the discogram and recommended a high-grade artificial disc at L4-L5 an anterior and posterior fusion device at L5-S1.

On April 22, 2009, M.D., denied the request for high-grade artificial disc at L4-L5 and a fusion device anterior and posterior at L5-S1 with the following rationale: *“The patient is noted to be two years post injury with continued back and leg pain that has not improved with conservative treatment. Diagnostic evaluation has determined that the claimant has spinal stenosis and instability for which disc processes at L4-L5 and 360-degree fusion at L5-S1 has been recommended. Evidenced-based medicine Official Disability Guidelines (ODG) does not recommend artificial disc replacement surgery because of the lack of long-term studies that prove it is superior to standard surgical intervention of fusion. Recent high-grade quality assessment has determined that there is insufficient evidence to draw extensive conclusion regarding the long-term effects of the implants, their durability, and local reaction to wear debris from the implants. While this patient may in fact be a candidate for a fusion, the surgical request for Hybrid ADR at L4-L5, two-day inpatient stay and one to two weeks later, 360 mini cannot be recommended.”*

On May 4, 2009, M.D., denied the appeal for Hybrid ADR at L4-L5 with two days inpatient length of stay with the following rationale: *“The requested disc replacement at L4-L5 cannot be justified. The rationale for the disc displacement is unclear. Notably, Official Disability Guidelines (ODG) do not favor artificial disc replacement surgery. There is insufficient evidence to determine the long-term viability of the implants. It is not clear the rationale for any surgery at the L4-L5 level as the claimant simply has degenerative changes without instability. The requested disc replacement adjacent to a fusion is not a standard technique for patients with some degenerative findings. For these reasons, the requested disc replacement cannot be justified based on the information reviewed”.*

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

Evidenced-based medicine Official Disability Guidelines (ODG) does not recommend artificial disc replacement surgery due to the lack of long-term studies proving it to be superior to a standard fusion.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES