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Notice of Independent Review Decision

DATE OF REVIEW: December 3, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4-L5 laminectomy facetectomy transforaminal lumbar interbody fusion (TLIF) cage with bone morphogenetic protein (BMP) posterolateral fusion with instrumentation and cell saver

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 the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male , who complained of pain in the back as he bent over to pick up a tray .

2008: On xxxxxx, M.D., evaluated the patient for pain in the lower back and left leg. The patient actually had a history of previous low back injury requiring surgical intervention by Dr. approximately 8-10 years ago, which included an L5 through S1 discectomy with anterior fusion. Postoperatively, the patient did very well and had resumed his regular work duties and had been pain free until this new injury. The patient complained of acute sharp pain in his lower back and left leg radiating in the buttock area down the length of his leg and into his foot and occasional pain in his right lower extremity associated with tingling and numbness primarily to the left foot. Examination revealed some mild left sciatic notch tenderness and positive straight leg raise (SLR) on the left. He had recently

undergone therapy with no significant relief of his symptoms and was referred for neurosurgical evaluation. Magnetic resonance imaging (MRI) of the lumbar spine done in March revealed postoperative changes at the lumbosacral junction compatible with a fusion at L5-S1, scattered lumbar spondylosis and moderate disc bulge, and mild bilateral foraminal narrowing at L4-L5 with mild spinal canal stenosis at L2-L3 and L3-L4 and mild developmental spinal canal stenosis at L2, L3, and L4. Dr. diagnosed lumbar disc displacement and recommended a lumbar epidural series. The patient had apparently seen a designated doctor who suggested maximum medical improvement (MMI) and 0% impairment. Dr. disagreed that the patient was at MMI as he only had one lumbar epidural. Additional treatment recommendations included a series of three lumbar epidurals, discogram, and an electromyography (EMG) of the left leg.

In June, the patient complained of a locking up sensation on getting up from a sitting position and occasional numbness to the left foot. He was referred to Dr. for pain management and to Dr. for disability determination.

In August, Dr. noted the patient had undergone two nerve blocks, but still continued to have significant back pain along with some pain in the thoracic region. His left leg symptoms were worse and there was more prominent numbness below the left knee to the foot.

A thoracolumbar myelogram with computerized tomography (CT) scan of the lumbar spine revealed non obstructing calculus on the lower pole of the left kidney. CT scan of the thoracic spine revealed posterior disc osteophyte complex at C5-C6 effacing the cerebrospinal fluid (CSF) with mild cord impingement and narrowing of the right foramen, minimal posterior disc osteophyte complex at C6-C7 with effacement of the CSF, small left paracentral disc osteophyte complex at C7-T1 with effacement of CSF, small central disc protrusion at T5-T6 with minimal effacement of CSF at T5-T6, and a small right paracentral disc protrusion at T8-T9 with mild effacement of the CSF.

Dr. noted the lumbar discogram had been denied. He opined the incident of presented an exacerbation of a pre-existing condition. The patient's injury affected the transitional segment above his previous lumbar fusion and there was an exacerbation of the pre-existing condition. There was a causal relationship between the incident of and his current condition.

In November, the patient was found to be under pain management with Dr. and on medications including morphine, Lyrica, and hydrocodone. A discogram at the L3-L4 and L4-L5 level was again requested.

2009: Dr. noted the lumbar discogram was denied. In a letter of denial, Dr., a board-certified orthopedic surgeon, opined that a discogram could be done at the L2-L3 levels and not use the L3-L4 level since it had a bulge and some stenosis. The patient underwent a lumbar epidural steroid injection (ESI) at the L4-L5 level. An MRI of the lumbar spine revealed mild disc desiccation at L1-L2, L2-L3, and L3-L4; mild disc desiccation and annular bulging at L4-L5, obscured L5 disc by some artifact, and mild-to-moderate right foraminal stenosis; however, related to spondylosis. Dr. noted three pain management consultations were denied. He prescribed Lyrica and requested for a fusion at L4-L5.

M.D., performed a required medical evaluation (RME) and rendered the following

opinions: (1) Current treatment was not appropriate and was no longer related to the event of xx/xx/xx. The effects of the work event consisted of a soft tissue lumbar strain, which should have been resolved in a short and finite period of time. There was no need of any prescription medications, durable medical equipment (DME), diagnostic testing, and supervised medical care in relationship to the effects naturally resulting from or flowing from the event of xx/xx/xx. (2) After the CT myelogram and its normal findings, he should have been instructed in the McKenzie exercise protocol and should be on over-the-counter (OTC) medications. (3) He was not a surgical candidate for the effects naturally resulting from the event of xx/xx/xx. There was no evidence of any significant adjacent segment abnormalities. The left SI joint was the pain generator and the diagnostic injection should be performed.

Dr. disagreed with the opinions of Dr. He felt the current treatment was appropriate and related to the injury as not every patient would have a radiographic sign on the diagnostic test. He recommended the patient should have supervised medical care, prescription medications, and the requested discogram, along with required pain management until his condition improved. If the patient continued to have some significant benefit, he should have therapy and could progress to hopefully home exercise program (HEP). The patient could possibly have an adjacent segment abnormality, but certainly had a bulging disc. As far as not being a candidate for discography, discography was a presurgical planning procedure to see whether or not the L4-L5 disc was his pain generator. Dr. refilled tramadol.

Post-discogram CT revealed: (1) Evidence of discectomy with disc spacer at the L5-S1 level, posterolateral osteophyte at this level and moderate right neural foraminal narrowing. (2) At L4-L5, discogram showed a prominent left posterolateral annular tear with extravasation of contrast delineating the margin of the disc in a left posterolateral location. (3) Nonobstructive calculus within the low pelvocaliceal moiety of the left kidney measuring 4.2 mm in diameter.

The patient continued to have significant amount of pain. Dr. opined the patient would benefit from an L4-L5 laminectomy, facetectomy, TLIF cage with BMP, posterolateral fusion with instrumentation and cell saver.

On October 12, 2009, M.D., a neurosurgeon, denied the request for lumbar laminectomy, facetectomy, TLIF cage with BMP, posterolateral fusion, instrumentation, and cell saver. Rationale: *"The patient had not undergone psychological evaluation and furthermore, RME had not recommended any further treatment. Based on the information provided, as well as the lack of psychological evaluation, this patient does not meet the criteria set forth in the Official Disability Guidelines (ODG) and medical necessity is not established."*

On October 28, 2009, Dr. noted decreased strength in the left and right iliopsoas, 4/5 dorsiflexors, and plantar flexors, pain with SLR, and decreased sensation to light touch and pinprick, worse on the left than on the right. Flexion and extension x-rays of the lumbar spine did not reveal any instability. Dr. again proposed that the patient should have a lumbar surgery.

On October 30, 2009, Attorney at Law, opined that Dr. I knew more about this patient's medical history and condition than anybody else, including the family doctor, as well as Dr. Further he confirmed how Dr. was well known for

conservative treatment and was a very highly regarded neurosurgeon in the community. Finally, another RME by a neurosurgeon and not by a family doctor or an orthopedic surgeon, to confirm Dr. expert opinion was requested.

On November 6, 2009, M.D., a neurosurgeon, denied the appeal for the request of lumbar laminectomy, facetectomy, TLIF cage with BMP, posterolateral fusion, instrumentation and Cell saver based on the following rationale: *“There is no evidence of an independent psychological evaluation and as stated by the initial reviewer, and RME recommended no further treatment.”*

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

MEDICAL MATERIAL REVIEWED LISTED IN NUMERICAL ORDER:

1. A REVIEW OF EVENTS WITH PATIENT CLINICAL HISTORY SUMMARY FROM MATUTECH INCORPORATED.
2. ODG GUIDELINES FOR LOW BACK CARE
3. ORTHOPEDIC SURGERY GROUP NOTES BY M.D., 2008 AND 2009. THE LAST REPORT BEING A TO WHOM IT MAY CONCERN LETTER ON 10/27/2009.
4. 9/2/2008 LUMBAR CT MYELOGRAM REPORT BY M.D.
5. MEDICAL EXAMINATION REPORT, 6/23/2009, BY M.D.
6. LUMBAR DISCOGRAM REPORT, 8/21/2009
7. 10/12/2009 DENIAL REPORT BY M.D., FOR AND A SIMILAR REPORT ON 10/5/2009, BY M.D.
8. 10/30/2009 LETTER BY ATTORNEY AT LAW

THIS CASE INVOLVES A MALE WHO ON XX/XX/XX, WAS BENT OVER PICKING UP A TRAY OF BREAD AND DEVELOPED LOW BACK PAIN. THE PAIN SOON EXTENDED INTO THE LEFT LOWER EXTREMITY AND TO A LESSER EXTENT INTO THE RIGHT LOWER EXTREMITY. THERE WAS A HISTORY OF AN L5-S1 FUSION FOR BACK PAIN APPROXIMATELY XX YEARS BEFORE WITH A GOOD RESULT. THE PATIENT WAS NOT HAVING BACK DIFFICULTY AT THE TIME OF THE XX/XX/XX INJURY. THE PATIENT

HAS HAD PHYSICAL THERAPY, MEDICATIONS AND EPIDURAL STEROID INJECTIONS WITHOUT SIGNIFICANT BENEFIT. A LUMBAR CT MYELOGRAM ON SEPTEMBER 2, 2008, SHOWED NOTHING IN THE WAY OF SIGNIFICANT FINDINGS. DISCOGRAPHY ON AUGUST 21, 2009, SHOWED CHANGES AT THE L4-5 LEVEL ON THE POST DISCOGRAPHY CT SCAN WHICH EXTENDED TO THE LEFT SIDE BUT THERE WAS NO CONCORDANT PAIN PRODUCED. LUMBAR FLEXION AND EXTENSION VIEWS HAVE FAILED TO REVEAL ANY INSTABILITY.

I AGREE WITH THE DENIAL FOR THE PROPOSED SURGICAL PROCEDURE INCLUDING FUSION AT THE L4-5 LEVEL. THERE IS NOTHING TO SUGGEST INSTABILITY ON FLEXION AND EXTENSION VIEWS OR IN THE PATIENT'S HISTORY. CHANGES CAN BE EXPECTED TO PRESENT AT THE L4-5 LEVEL SECONDARY TO THE FUSION 10 YEARS BEFORE BECAUSE OF THE STRESS PLACED ON THAT JOINT BUT THE CT MYELOGRAM HAS FAILED TO REVEAL ANY SIGNIFICANT EVIDENCE OF NERVE ROOT COMPRESSION. IN ADDITION, THE DISCOGRAPHY WHILE SHOWING SOME EXTRAVASATION OF THE MATERIAL TO THE LEFT AT THE L4-5 LEVEL, DOES NOT MENTION ANY CONCORDANT PAIN BEING PRODUCED AND THE CHANGES DESCRIBED COULD BE EXPECTED SECONDARY TO DEGENERATIVE CHANGES IN THIS L4-5 LEVEL. NOTHING IN THE RECORDS I REVIEWED INDICATED ANY DIFFERENT EVIDENCE OF SIGNIFICANT NERVE ROOT COMPRESSION AND IN ADDITION TO THAT THERE IS NO EVIDENCE OF INSTABILITY AND UNDER THOSE CIRCUMSTANCES, THE PROPOSED OPERATIVE PROCEDURE IS NOT INDICATED.

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