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Notice of Independent Review Decision

DATE OF REVIEW: January 19, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L5-S1 minimally invasive lumbar decompression and fusion

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

Board Certified Orthopedic Surgeon

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

TDI

- Utilization reviews (11/30/09, 12/04/09)
- Utilization reviews (08/05/09, 11/30/09, 12/04/09)
- Diagnostics (10/22/08 – 07/16/09)
- Office visits (10/30/08 – 03/13/09)
- Peer review (03/30/09)
- DDE (10/29/09)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male who was injured at work while lifting a heavy piece of iron on xx/xx/xx. He felt a pop in his lower back and developed severe onset of low back and leg pain.

: Following the injury, the patient was seen at emergency room (ER) where x-rays were negative for fracture. He was treated with prednisolone, Valium, Ultram, Vicodin, Zanaflex, and ibuprofen.

Magnetic resonance imaging (MRI) of the lumbar spine showed severe disc degeneration at L5-S1 with moderate diffuse bulge causing a moderate degree of stenosis of the left L5-S1 neural foramen and probable impingement of the exiting left L5 nerve root.

M.D., a neurosurgeon, evaluated the patient for left leg radicular pain and low back pain associated with tingling and numbness, extending down the posterior thigh and calf into the bottom of his foot on the left. Examination revealed positive straight leg raise (SLR) on the left. Dr. diagnosed displaced lumbar intervertebral disc and degeneration of lumbar/lumbosacral intervertebral disc and treated him with a program of physical therapy (PT) and pain medications, muscle relaxants, and Medrol Dosepak to his regimen. The numbness in the leg improved but pain persisted. Dr. recommended foraminal nerve root injection at L5 on the left. Prescription of Zoloft was provided for his depressive mood.

2009: Dr. noted injection did not provide any relief, in fact, worsened the pain. The patient ambulated with a severely antalgic gait. SLR was positive on the left and ankle jerks were diminished. Dr. believed the patient had reached maximum medical improvement (MMI). In order to improve the leg pain, he recommended a lumbar discectomy at L5-S1 on the left, but in view of degenerative findings, he recommended a minimally invasive posterior lumbar decompression and fusion at L5-S1.

On March 30, 2009, M.D., performed a peer review. He had performed another peer review in October 2008 excerpts from which are as follows: *The diagnosis was acute lumbar strain, superimposed on severe degenerative changes at L5-S1 with possible impingement on the left L5 nerve root. In February 2009, M.D., performed a designated doctor evaluation (DDE) and deferred assessment of MMI, pending surgical consultation. Additional ESIs were denied as the first ESI did not help.* Dr. rendered the following opinions: (1) As no objective evidence of radiculopathy was noted on physical examination, electromyography/nerve conduction velocity (EMG/NCV) should be performed. If it showed evidence of radiculopathy then surgery would be an option per the Official Disability Guidelines (ODG). (2) Due to the psychological symptoms in the patient combined with symptom magnification coupled with no spondylolisthesis per the records, he did not appear to be a suitable candidate for fusion, per ODG criteria. (3) No additional injections or durable medical equipment (DME) was recommended.

In a psychological evaluation, Ph.D., diagnosed pain disorder associated with both psychological factor and a general medical condition and major depressive disorder. He stated that the patient presented with several psychological risk factors for poor surgical outcome. There were several behavioral interventions required to improve his response to intervention, which would include reduction of narcotic medications preoperatively to improve response to analgesic medications, weight reduction to reduce physical load on his spine thereby improving surgical efficacy, participation in an aerobic exercise program, and use of antidepressive medications, which could alleviate depressive symptoms.

In July, x-rays of the lumbar spine showed degenerative changes of the facet joints at the level of L5-S1 with disc space narrowing at L5-S1 and possible canal stenosis at the level of L5-S1. There was no rotational instability.

On August 5, 2009, M.D., denied authorization for an appeal for lumbar decompression with discectomy and fusion at L5-S1 with the following rationale: *"The ODG does not support fusion in the absence of instability. There is no documented instability in this claimant"*.

On October 29, 2009, Dr. diagnosed lumbar strain and sprain aggravating L5-S1 degenerative disc disease (DDD) with herniation, left sacral root compression, and radiculitis. He opined the patient was not at MMI. Dr. stated the patient was worse since his last examination. He ambulated with a limp. The patient did not have atrophy or reflex changes and the correct diagnosis would be radiculitis rather than radiculopathy. Dr. agreed with Dr. regarding spinal fusion with disc excision. He recommended a trial of Neurontin and weaning the patient off Soma, pending surgery.

On November 30, 2009, M.D., denied the authorization for surgery with the following rationale: *"Based on the medical records submitted for review on the above referred claimant, surgery requested was not approved. The claimant may need surgery, but not lumbar fusion. There is no evidence of instability."*

On December 14, 2009, M.D., non-authorized the reconsideration for lumbar decompression with discectomy and fusion at L5-S1 with pedicle screw instrumentation and Allograft with assistant and three day inpatient stay as not medically necessary.

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

On overview of these records it is quite concerning that the psychologist identified several psychological risk factors for a poor surgical outcome. The most recent imaging study available is over one year old, and appears to reveal only a degenerative disc condition. Although injections have reportedly been unsuccessful it is unclear the duration for which medications have been provided. It is unclear the duration for which physical therapy or other manipulative interventions may have been provided. It is unclear whether or not there is a smoking history and if so whether or not this young patient has been counseled regarding the same. For these reasons the records presented would not satisfy ODG Guidelines for lumbar fusion. As such the fusion could not be recommended as medically necessary based on the guidelines.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**