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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 23, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient posterior lumbar decompression with 1-2 days length of stay including 63048, 63047 and 69990

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

XXXXXX

- Diagnostics (10/28/09 – 01/11/10)
- Office visits (12/22/09 – 02/09/10)
- Operative report (12/11/09)

TDI

- Utilization reviews (02/05/10 – 02/22/10)

Dr.

- **Diagnostics (10/28/09 – 01/26/10)**
- **Office visits (11/17/09 – 03/09/10)**
- **Operative report (12/11/09)**

ODG have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who struck a hole on xx/xx/xx. He jolted his back and developed lower back pain.

In October 2009, magnetic resonance imaging (MRI) of the lumbar spine revealed a congenitally-small spinal canal predisposing to spinal stenosis, moderate central and paracentral disc protrusion at L4-L5 superimposed on a mild broad-based disc bulge with small midline annular tear combining with moderate degenerative facet changes and ligamentum flavum hypertrophy (left greater than right) resulting in moderate spinal stenosis with appearance of encroachment on L5 nerve roots bilaterally. Mild-to-moderate central and paracentral disc protrusion at L3-L4 with borderline-to-mild spinal stenosis. Mild disc bulge at L2-L3 with small midline annular tear and borderline spinal stenosis.

On November 4, 2009, electromyography and nerve conduction velocity (EMG/NCV) of the lower extremities showed bilateral L4, L5 and S1 acute radiculopathy and chronic denervation of right S1.

, M.D., noted complaints of low back pain radiating into the legs occasionally, numbness of the arms, insomnia and depression. The ongoing medications included Darvocet-N, Flexeril and Ambien. Surgical history was positive for right knee surgery and appendectomy. Examination showed decreased sensation on left leg posteriorly, decreased cervical and lumbar range of motion (ROM), positive FABER on the left and positive straight leg raise (SLR). X-rays of the lumbar spine showed spurring at L2 and some at T12- L1. Dr. diagnosed lumbar stenosis with disc protrusion at L4-L5 greater than L3-L4, tobacco habituation and cervical strain with possible radiculopathy, performed a left transforaminal ESI at L3-L4 and L4-L5, recommended decreasing the dose of Darvocet-N and continuing therapy and ordered a TENS unit. The patient had no enough improvement with the injection. He complained of intractable pain at the lumbar spine into both lower extremities. Examination revealed positive SLR with pain into the lower extremities down into the calf and difficulty on heel and toe walking. Dr. obtained myelogram of the lumbar spine that revealed moderate indentation on the anterior aspect of the thecal sac adjacent to the level of disc at L3-L4 and L4-L5 consistent with posterior protrusion at these levels. Post-myelogram computerized tomography (CT) scan revealed central disc protrusions at L3-L4 and L4-L5 encroaching the anterior epidural space in the midline creating moderate AP spinal stenosis at these levels, L3-L4 was narrowed to approximately 5.5 mm and L4-L5 was narrowed to 7 mm; broad-based posterior disc protrusion at L2-L3 slightly more prominent at the right of midline; 3-mm anterolisthesis of L5 on S1 with some unroofing of the disc and prominent anterior epidural space posterior to L4 and L5 and prominent Schmorl node defect at L4 with small Schmorl nodes at L1, L2 and L3.

On January 26, 2010, Dr. noted the pain in the left leg down into the calf was worse and the strength was not quite as good. X-rays of the lumbar spine revealed early spondylolisthesis at L5-S1. He recommended surgical decompression based on the severe narrowing noted at L4-L5 and lesser at L2-L3 and L3-L4.

Per utilization review dated February 5, 2010, the request for inpatient posterior lumbar decompression with one to two days length of stay was denied with the following rationale: *“Although the patient has demonstrated focal neurological deficits and pathology present in the lumbar spine, the request is nonspecific as to what levels should be included in the request. The most recent clinical note does not distinguish what levels should be included in the request and additional information would be needed in order to determine the medically necessary. As such, the request as submitted is not recommended as medically necessary at this time.”*

On February 9, 2009, Dr. requested peer-to-peer with the doctor who should be a spine surgeon. He stated the levels were L3-L4 and L4-L5 and to a lesser degree the L2-L3 level.

Per utilization review dated February 22, 2009, an appeal for inpatient posterior lumbar decompression with 1-2 days length of stay was denied with the following rationale: *“The clinical information provided for review did not meet the practice guidelines for the use of the requested procedure as referenced above. The patient presents with*

intractable pain at the lumbar spine into both lower extremities, left worse than right with imaging studies demonstrating disc protrusion at L3-L4 and L4-L5 and mild-to-moderate spinal stenosis. No comprehensive back and neurologic examination however was submitted for review; he has a positive SLR and difficulty of heel and toe walking, but no motor, sensory and reflex changes were noted referable to the involved segments. There were no reported bowel or bladder control problems. He had undergone a trial of ESI with no apparent improvement, but aside from this modality, no other records provided of other conservative treatment done such as PT and optimized pharmaceutical treatment. As such, the appropriateness, medical necessity, and anticipated benefits of this requested procedure are not sufficiently substantiated."

On March 9, 2010, Dr. stated the possibility of the patient developing cauda equina as he had significant pathological findings. He stated that the CT myelogram findings were significant and related to the disc protrusions and to the work injury, and not to the degenerative changes of life. He further stated that the denial of the surgery was inconsistent with appropriate clinical management and believed that an IRO would be necessary.

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

The requested lumbar decompression surgery at L4-5 and at L3-L4, L2 level is also involved but to a lesser degree, with a 1 to 3 day length of stay is not medically necessary based on review of this medical record.

This reviewer understands this patient has symptomatic lumbar spinal stenosis which appears to be at the L4-L5 more so than the L3-L4 level. This patient has positive physical findings and abnormal EMG testing as well as a CT myelogram documenting significant stenosis. What this reviewer doesn't quite understand is whether or not Dr. is actually going to do the L2-L3 level which is not clear in the medical records provided. It is also not clear in the medical records as to whether or not there is any thought to the L5-S1 spondylolisthesis and whether that is causing any of the patient's symptoms since the EMG study did show acute and chronic S1 radicular changes. Therefore, while this reviewer understands the need for surgical intervention, it is difficult to authorize surgery when the requested procedure is nonspecific.

Therefore, based on the fact that Dr.'s records are not clear as to the level of surgery, then this surgical procedure is not medically necessary. While Dr.'s most recent medical record documents the fact the patient may develop cauda equina in the future, clearly the records at this time do not document myelopathy or cauda equina syndrome and if the treating practitioner's medical records were a little more clear, it might be easier to actually process his surgical request.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES