

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** November 15, 2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

LSO brace, L0636 (spine surgery)

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

Fellow American Academy of Orthopaedic Surgeons

**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**

- Office visits (01/05/07 –09/03/10)
- Diagnostics (01/05/07 – 09/23/10)
- Utilization review (06/25/07 – 07/30/07)
- Procedures (02/22/07 – 08/30/07)

[ODG has been utilized for the denials.](#)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient who was involved in a hit and run automobile pedestrian accident on xx/xx/xx. He was thrown 18 feet in the air, hit the windshield of a vehicle and lost consciousness.

He was taken to emergency room (ER) via ambulance where they obtained x-rays of the pelvis, chest, thoracic and cervical spine – all of which were normal. Computerized tomography (CT) of the cervical spine revealed posterior

osteophyte formation at C5-C6 mildly narrowing the spinal canal. CT scan of the brain was unremarkable. CT of the chest/abdomen/pelvis revealed mild dependent atelectasis, small hypodensity within the lower pole of the right kidney, small punctate calcification within the liver, degenerative changes in the lumbar spine particularly prominent at L5-S1 with disc height loss and osteophyte formation. The patient required stitches for the laceration on his face and was discharged the same day.

Since the injury, the patient complained of headache on a daily basis with associated positional dizziness and had been taking ibuprofen. He also complained of pain radiating to the right arm and was noted to have tenderness in the acromioclavicular joint (AC) joint on the right.

A magnetic resonance imaging (MRI) of the right shoulder was obtained which revealed full-thickness rotator cuff tear. The patient underwent right shoulder arthroscopy, debridement of partial biceps tendon tear, subacromial decompression and acromioplasty and mini-open rotator cuff repair on February 22, 2007, followed by postoperative rehabilitation.

MRI of the right knee showed moderate diffuse chondromalacia and tears of the anterior and posterior horns of the medial meniscus. He underwent right knee arthroscopy and partial medial meniscectomy on April 2, 2007. Postoperatively, the patient was advised to increase his activities as tolerated. He also complained of back pain, ringing in ears and breathing problems. He was therefore referred to a neurologist and pulmonologist.

An MRI of the lumbar spine was obtained for complaints of back pain. This showed: (1) Congenital spinal stenosis from L1-L2 through L4-L5 due to short pedicles. (2) At L4-L5, mild dorsal bulge with superimposed 4 or 5 mm left paracentral and foraminal disc protrusion. There was left foraminal annular fissuring. Moderate left foraminal encroachment, with probable flattening of the emanating left L4 root. Mild-to-moderate central stenosis with mild lateral recess encroachment by laterally. (3) At L5-S1, mild-to-moderate spondylosis on circumferential chronic protrusion, mild-to-moderate foraminal stenosis with contact of emanating L5 roots and flattening of the emanating right L5 root and borderline right recess encroachment.

An electromyography/nerve conduction velocity (EMG/NCV) of the lower extremities revealed severe generalized sensory motor neuropathy with both axonal demyelinating features and proximal denervation suggestive of radiculopathy and/or neuropathy.

Right shoulder arthrogram showed full-thickness tear of the rotator cuff, which appeared to be near the insertion of the supraspinatus tendon and mild-to-moderate osteoarthritis changes of the AC joint with some enthesopathy.

The patient obtained a pulmonology consultation for shortness of breath (SOB) at night while lying down. Examination revealed poor exercise tolerance, cough, wheezing and night sweats. Pulmonary function tests (PFTs) were completely normal. A repeat x-ray revealed suboptimal inspiratory effort and small nodule.

The patient was advised to undergo further diagnostic studies to exclude physiological reason for his shortness of breath while lying down and diaphragmatic dysfunction. X-rays of the chest revealed 5-mm nodular opacity projecting over the left costophrenic angle.

On August 30, 2007, the patient underwent arthroscopic right distal clavicular resection, right shoulder therapeutic manipulation under anesthesia and subacromial decompression.

The patient underwent sniff test for shortness of breath which was normal. Audiometric evaluation revealed mild, high frequency sensorineural hearing loss in both ears and he was advised to use hearing protection in all noisy environments.

In September 2007, the patient was seen at Neurological Institute and was diagnosed with postconcussive syndrome with superimposed tension headache; (the latter clinically improved with nortriptyline) and chronic tinnitus. He was advised to resume his nortriptyline and follow-up after three to four months.

In October 2007, the patient was seen by M.D., for pain in the lower back with exacerbation on bending forward into flexion and sitting for long time. Valsalva maneuver such as coughing, sneezing and straining made the pain worse. On examination, pain was reproduced by bending forward into flexion. X-rays showed significantly narrowed disc space height at the L5-S1 level with anterior and posterior syndesmophyte formation. Dr. reviewed the MRI of the lumbar spine obtained on June 15, 2007, and diagnosed disc herniation at L4-L5 with annular fissuring and disc herniation at L5-S1 with associated spondylotic changes. He treated the patient with three weeks of PT with modest improvement.

**2008 – 2009:** The patient was diagnosed right ulnar nerve compression, right shoulder AC sprain/strains, right impingement tendon disorder and right frozen shoulder. He was placed at maximum medical improvement (MMI) in regards to the shoulder on January 23, 2008, and assigned 9% impairment rating (IR). A functional capacity evaluation (FCE) placed him in the medium physical demand level (PDL).

Dr. noted significant reduction of symptoms with conservative measures and released the patient to full duty work. However, the patient reported exacerbation of his low back pain as he tried to get out of bed. He was prescribed anti-inflammatory medications and was advised to use a soft lumbar corset over the course of next week.

**2010:** The patient was noted to have deterioration of the motion segment at L5-S1 with bone on bone contact at the L5-S1 level, facet joint arthropathy and a right-sided lumbar radiculopathy. He again presented in March with persistent complaints of back and right lower extremity pain, made worse with activity. Sensory testing showed diminished dermatomal sensory function over the L4 dermatome on the right.

X-rays showed significant narrowing of the disc space at the L5-S1 level with near bone-on-bone contact and prominent anterior syndesmophytes. There was evidence of posterior element hypertrophy consistent with facet joint enlargement. A repeat MRI showed: (1) At L3-L4: 1 mm retrolisthesis of L2. 2 or 3 mm symmetric broad-based posterior protrusion mildly indenting the sac. Mild bilateral foraminal narrowing without nerve root displacement and mild bilateral facet arthrosis. (2) At L4-L5: Very mild narrowing along with 2 mm retrolisthesis of L4, 4-mm broad-based posterior protrusion with mild left posterolateral accentuation abutting the sac. Moderate bilateral facet arthrosis. Mild right and moderate left foraminal narrowing and associated left posterolateral annular tear, mild effacement of the left L4 nerve root/torsed root ganglion, but no displacement of either nerve root sleeve. (3) At L5-S1: Marked disc space narrowing, chronic degenerative endplate changes, 3 or 4 mm bony and distal posterior protrusion, with posterolateral accentuation abutting the right S1 nerve root sleeve. Moderate bilateral facet arthrosis and mild right lateral recess stenosis, moderate to marked and right and left foraminal narrowing. There was effacement of the emanating L5 nerve root sleeve bilaterally, right greater than the left. Dr. reviewed the MRI and suggested surgical intervention consisting of right-sided decompression at L4-L5 and L5-S1 with compression of the S1 nerve root on the right as well as lateral recess decompression at L4-L5 on the right to address the L5 nerve root. The patient was cleared for surgery by a psychologist on September 10, 2010.

M.D., continued to see the patient for his right shoulder complaints. An MRI of the cervical spine revealed disc protrusion at C6-C7 and disc bulges at C4-C5 and C5-C6 with an element of borderline central stenosis at C5-C6.

On October 1, 2010, the request for the LSO brace was not certified with the following rationale: *“The patient is noted to have sustained injury in xx/xx. His condition has been refractory to conservative treatment. There appears to have been a lapse in treatment from November 2008 through March 16, 2010. The patient has evidence of degenerative changes of the lumbar spine; however, there is no instability at any level. The patient reportedly had epidural steroid injections, but the response to these injections is not reported. There is an indication that the patient had undergone psychological evaluation on September 10, 2010, but this report was not submitted for review. The most recent physical examination is over six months old, but at that time, there was no significant neurologic deficit with normal motor strength and reflexes. There was some diminished sensation of the L4 dermatome on right compared to left. Medical necessity is not established for surgery and therefore postoperative LSO brace is not indicated.”*

On October 14, 2010, the appeal for the LSO brace was denied. Rationale: *“This patient does not have fracture or instability which would warrant a lumbar brace. The request for the two-level spine surgery is not approved. Thus the request is not a medical necessity per ODG criteria”.*

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

*The treating physician has requested a two level lumbar spine surgery with fusion which has been denied. The brace is used for postoperative care. Since the surgery has not been approved, the brace is not approved. There is no documentation that this patient has fracture instability that requires a lumbar brace other than for postoperative care. There is also no documentation that the patient has had a physical examination by his treating physician for close to four months. Therefore the need for the lumbosacral orthosis is not recommended or approved at this time.*

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**