

MATUTECH, INC.

PO BOX 310069
NEW BRAUNFELS, TX 78131
PHONE: 800-929-9078
FAX: 800-570-9544

DATE OF REVIEW: August 5, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar laminectomy with fusion and instrumentation of L1-L2, 99222, 22830, 22852, 63044-50, 22630, 22851x2, 22612, 22614x2, 20937, 22842, 37202-59, 11981-59, 20975, TLSO back brace, 1 night length of stay.

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

I am a board certified neurosurgeon who has been board certified since 1974 and finished my training in neurosurgery at Baylor College of Medicine in 1972.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

Medical documentation **supports the medical necessity** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Dr:

- Diagnostics (09/18/02 – 12/10/10)
- Surgeries (04/02/03 – 07/23/08)
- Office visits (09/12/10 – 06/16/11)

i:

- Office visits (05/18/09 – 06/16/11)
- Diagnostics (08/10/09 – 12/10/10)
- IRO (05/12/11)
- Utilization reviews (06/23/11 – 03/22/11)

TDI:

- Utilization reviews (06/23/11 – 07/07/11)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained injuries to her neck and lower back after lifting a box of dishes.

1994 – 2001: No records are available.

2002 – 2005: From September 2002 through October 2005, the patient was seen by, M.D., a neurosurgeon, for increasingly severe posterior cervical and interscapular pain with bilateral radiating shoulder and arm pain made worse with activities. The patient was status post lumbar surgery. History was positive for hypertension and cervical spine degenerative changes with foraminal encroachment bilaterally from C3 through C6 on computerized tomography (CT) scan of the cervical spine. Examination showed flexed head and neck; diminished mobility of the neck in all directions with reproduction of bilateral shoulder and arm pain with neck extension and bilateral bending. Examination of the upper extremities showed diminished strength and scattered hypalgesia. Dr. obtained multiple CT myelogram studies of the cervical spine and diagnosed chronic pain with central disc disease and probable radiculopathy. Magnetic resonance imaging (MRI) of the cervical spine was unremarkable.

On April 2, 2003, Dr. noted following treatment history: *“The patient was originally referred by Dr.. She was injured in xxxx while at work for the and had right L3-L4, L4-L5 and L5-S1 decompression in February 1995 with initial good results. However, she developed a chronic mechanical low back disorder with radiculopathies and underwent bilateral L2-L3, L3-L4, L4-L5 and L5-S1 decompression with bilateral L3 through S1 fusion with pedicle screws and rods and an L4-L5 cross link and left iliac monetized donor graft in October 1997. She initially did very well following that procedure; however, in January 2001 she was seen in the office and felt that her legs were giving way on her when she slipped and fell because her legs were weak in December 2000. Since that time she had markedly increased low back pain and bilateral radiating hip and leg pain with numbness, dysesthesia, and a feeling of weakness in the legs. She was felt to have a solid fusion from L3 to the sacrum and was using a walker. Lumbar myelogram and CT scan were done and showed significant L2-L3 stenosis. She was taking medications and had steroid injections and physical therapy (PT) but continued to be quite symptomatic. Dr. performed exploration of the previous fusion, removal of L3 pedicle screws and rods, recurrent microscopic L2-L3 decompressive laminectomy, recurrent microscopic bilateral L2 and L3 root decompression, microscopic bilateral L2-L3 excision of herniated disc with root decompression, bilateral L2-L3 anterior spinal column arthrodesis and interbody cages, bilateral L2 through L4 posterolateral fusion, bilateral L2 and L3 pedicle screws and plates and morcellized autograft. The patient had excellent relief of her hip and leg pain and was walking much better.*

In February 2004, the patient developed pain radiating from the mid lumbar area into the right inguinal and groin area and into the right proximal anterior thigh. Dr. LeGrand obtained CT myelogram, x-rays and MRI of the lumbar spine and treated the patient with lumbar steroid injection with good relief. On follow-up, the patient complained of severe mid cervical pain with bilateral shoulder and arm pain. Studies revealed C3-C4 and C4-C5 disc disease with central protrusion at both levels and some foraminal constriction.

On August 17, 2004, Dr. performed anterior discectomy at C3-C4 and C4-C5 with bilateral C4 and bilateral C5 root decompression with excision of herniated disc, interbody fusion of C3-C4 and C4-C5, placement of interbody cage allograft

at C3-C4 and C4-C5, morcellized autograft interbody at C3-C4 and C4-C5 and application of anterior plate at C3, C4 and C5. Postoperatively, she did well and reported minimal pain. Dr. referred her to an orthopedic surgeon for her right shoulder pain.

2006 – 2010: From March 2006 through December 2010, the patient was seen by Dr. LeGrand for low back and left leg radicular pain. Examination showed antalgic gait and a positive straight leg raise (SLR) test. Dr. prescribed hydrocodone and recommended lumbar epidural steroid injection (ESI).

On July 23, 2008, Dr. performed decompressive L1, L2 laminectomy, bilateral L1 and L2 root decompression with opening of lateral recesses and foraminotomy, bilateral L1-L3 posterolateral fusion, morcellized autograft and placement of infusion catheter. Postoperatively, the patient did well and reported good strength and sensation in the lower extremities. The patient then reported ongoing thoracolumbar pain and was started on Darvocet and Motrin.

In March 2010, Dr. noted increasingly severe neck pain and bilateral radiating shoulder and arm pain. He obtained a CT myelogram of the lumbar spine and noted multifactorial stenosis at L1-L2 with a large disc extrusion paracentrally and to the left. The patient reported pain radiating into the proximal left anterior thigh. Dr. noted some weakness of the left quadriceps and left hip flexors. In December, Dr. performed right L1-L2 epidural Depo-Medrol injection.

2011: In January, the patient reported some benefit from L1-L2 epidural Depo-Medrol injection. Dr. refilled hydrocodone and recommended L1-L2 decompression for increasingly severe upper lumbar pain with bilateral radiating pain into the hips and legs with increasing numbness and weakness in the lower extremities. However, the surgery was denied.

On May 10, 2011, an independent review organization (IRO) upheld the denial of inpatient 3-day stay for laminectomy at L1-L2 with fusion instrumentation and back brace at Medical Center.

On June 16, 2011, Dr. opined the patient had very severe stenosis and a large disc extrusion at L1-L2 with significant neurological deficit with numbness, dysesthesias and weakness in the lower extremities. He recommended further fusion and pedicle screw and plate instrumentation.

Per utilization review dated June 23, 2011, the request for inpatient 1 day stay, lumbar laminectomy with fusion and instrumentation at L1-L2, and TLSO back brace was denied with the following rationale: *“The claimant has had flexion/extension films in the past which did not document any segmental instability at the L1-L2 level. Guidelines do not support fusion in the absence of clear segmental instability. The claimant is having significant complaints of pain and has findings on physical examination and ultimately may warrant discectomy.”*

Per reconsideration review dated July 1, 2011, the appeal for inpatient 1-day stay/DME, lumbar laminectomy with fusion and instrumentation at L1-L2 and TLSO back brace was denied with the following rationale: *“Patient with a L2-S1 fusion. The claimant now has low back pain and degenerative disc disease*

(DDD) at L1-L2. Stenosis is present at L1-L2 both central and neuroforaminal. Extensive conservative management including injections has not provided relief, which is problematic – blame cannot readily be assigned to the L1-L2 level. Other multifactorial sources of chronic pain have not been definitively ruled out. In fact on April 5, 2010, and other dates, even Dr. opined that the L1-L2 stenosis was multifactorial. He presented no evidence to corroborate an injury related to the claim. There has been no demonstration of instability at L1-L2, which is a prerequisite for fusion per ODG. From the records herewith, it is unknown whether the claimant has had preoperative psychological evaluation. On May 12, 2011, IRO upheld previous denial of requests for this surgery. Denials for this proposed surgery date back to 2008.”

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

Summary

This is a woman who has had multiple problems with her spine for many years.

She has had spine fusions performed by Dr. on multiple occasions. A very detailed summary is incorporated in the notes here and I will not go into repeating everything that is being said.

Briefly, the patient has had continued difficulty with a new level of pathology noted at L1-L2.

A herniated disc with stenosis has been noted on imaging studies confirming the abnormalities clinically with progressive back pain and going into the upper thigh.

The review is based on ODG criteria for decompression, discectomy, and fusion.

The review outcome basically, I disagree with the previous denial and feel that the surgical procedure of decompression, discectomy, and stabilization with fusion is indicated in this patient.

Based on the information provided, I believe that the stenosis present at L1-L2 both centrally and intervertebral foraminal, need to be decompressed since there is a large herniated disc increasing the spinal stenosis. Certainly after the surgery which would decompress that area and stabilize it, the patient will need a support of a TLSO back brace. Based on the ODG criteria, this patient should indeed be subjected to the surgical intervention requested by, M.D.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**