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Notice of Independent Review Decision

DATE OF REVIEW: April 21, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient lumbar laminectomy with fusion + instrumentation at L5-S1 with length of stay one day 63030, 63035, DME: TLSO back brace + bone stimulator L0464

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

Diplomat, American Board of Orthopaedic Surgery
Fellowship trained in spine 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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx. He was loading very heavy lock hammers and had onset of low back pain and bilateral hip and leg pain.

He was seen on March 26, 2007, by M.D. for gradual increase in low back pain exacerbated by walking, standing and activities. He had undergone work hardening program (WHP) and physical therapy (PT) and was utilizing Ultracet and Skelaxin. Lumbar magnetic resonance imaging (MRI) showed a central and right paracentral L5-S1 disc protrusion. History was positive for splenectomy in 1989, post traumatic. Examination revealed decreased mobility of low back with some paralumbar muscular tightness and the patient walked with a slight flexed posture at the low back and had some loss of lumbar lordosis. There was slight tenderness over both sciatic outlets and deep tendon reflexes were 2+ in the knees and traces in the ankles. The patient was diagnosed with chronic mechanical low back disorder, post traumatic with MRI evidence of L5-S1 disc protrusion and with probable radiculopathies.

A post myelogram CT of the lumbar spine revealed mild-to-moderate central bulging of the disc causing mild-to-moderate encroachment upon the central aspect anterior portion of the dural sac. There was an 18 mm soft tissue density along the posterolateral aspect of the upper pole of the left kidney. This extended down to the kidney and an exophytic mass arising from the left kidney could not be excluded. A CT of the abdomen was recommended for further investigation but the patient was unable to get the CT.

The patient underwent a lumbar epidural steroid injection (ESI) with good results.

D.O., reported that 10 sessions of WHP had improved the patient's condition. He placed the patient at clinical maximum medical improvement (MMI) on May 16, 2007, assigned impairment rating (IR) of 5% and released the patient to full duty work.

The patient tried to work but complained of severe low back pain. A second lumbar ESI was performed on October 10, 2007. But the patient continued to have pain. A diagnostic discography was recommended to localize pain generator, but this was denied.

On December 10, 2009, x-rays of the lumbar spine was unremarkable. The patient went to the Clinic for lumbar back pain/strain, was treated with injection Decadron and given prescription for Lodine, Flexeril, Ultram and Flector patches and recommended application of ice/heat.

MRI revealed central right paracentral disc protrusion at L5-S1 with effacement of the thecal sac, but no significant stenosis or compromise of the lateral recesses. As the patient continued to have pain he was referred to a spine specialist.

On February 21, 2011, Dr. requested proceeding with surgery.

M.D. denied the request for surgery with the following rationale: "Medical record dated February 21, 2011 showed persistent low back pain. Current physical examination revealed positive straight leg raise test on the left at 60 degrees and less than 45 degrees on the right. There is decreased sensation in the distal right S1 dermatome. There is loss of lumbar lordosis and paralumbar muscle tightness. Conservative management is the cornerstone in the initial treatment of low back pain. There was no documentation provided with regard to the failure of the patient to respond to conservative measures such as evidence-based exercise

program and medications prior to the proposed surgical procedure including the objective response and the procedural report of the previous epidural steroid injection. Also there are no therapy progress reports submitted for review to validate that the patient has had sufficient number of therapy as well as optimized pharmacological treatment. The maximum potential of the conservative treatment done was not fully exhausted to indicate a surgical procedure. With this, the necessity of the request could not be established at this time. Subsequently the request for bone fusion stimulator, one day length of stay and the purchase of TLSO back brace is not certified”.

Dr. placed an appeal, but this was again denied by M.D. Rationale: “Records indicate that there was an adverse determination of a previous review. In acknowledgment of the previous non-certification due to lack of documentation of failure of conservative treatments, there is now documentation that the medical record dated February 10, 2011, showed persistent low back pain. Current physical examination revealed positive bilateral straight leg raise test at 45 degrees with depressed deep tendon reflexes on both ankles. There is paralumbar tightness with loss of lumbar lordosis, MRI showed at L5-S1 compression and desiccation of the disk with a central protrusion present that extends into the epidural fat and mildly effaces the thecal sac centrally and somewhat to the right. There is no definite nerve root compression. Treatment has included medication, ESI, and physical therapy. However, there is no clear documentation of associated clinical findings such as loss of relevant reflexes, muscle weakness and/or atrophy of appropriate muscle groups, loss of sensation in the corresponding dermatome and imaging showing nerve root compression and instability. Therefore, based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request for appeal lumbar laminectomy with fusion and instrumentation L5-S1, bone fusion stimulator, one day length of stay and the purchase of TLSO back brace is non-certified”.

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

This patient is, 5’10”, approximately 163 lbs. He was initially seen by Dr. (M.D.) per the forwarded records on. The patient had a work incident doing heavy lock hammers with onset of low back pain and bilateral hip and leg pain. The patient had an MRI completed showing a central and right paracentral L5-S1 disc protrusion per Dr.. The patient had a previous history of splenectomy in 1989.

On exam, he was noted to have normal strength and sensation as well as reflexes in the lower extremities. He had tenderness over both sciatic outlets and straight leg raise reported as positive for back pain and posterior thigh pain at 45 degrees.

On April 3, 2007, Dr. performed a myelogram which was subsequently interpreted by himself but also by Dr. (M.D.) noting no abnormalities on the lumbar myelogram. The post-myelogram CT scan also interpreted by Dr. noted moderate central bulging of L5-S1 disc. There was no nerve root compression distinctly identified.

The patient then had an epidural steroid injection performed on May 4, 2007, by Dr. which was repeated on October 10, 2007. Please note that Dr. (D.O.) placed

the patient at maximum medical improvement on May 6, 2007, with a 5% impairment rating.

The patient then was not apparently seen until December 2009 when we have x-ray report from Hospital. Two views of the lumbar spine were done with only the clinical history of lumbar pain. These x-rays showed no acute abnormalities.

A lumbar MRI was completed on January 14, 2010, at Hospital. This showed L5-S1 to have desiccation of the disc with a central protrusion that extended into the epidural fat. There was no definitive nerve root compression. This was interpreted by Dr. (M.D.).

On February 21, 2011, Dr. re-evaluated Mr. noting the history of his back dysfunction. He reported that he had tried to get discography which was denied by Workers Compensation previously. The patient was also having hip discomfort and Dr. noted that the back pain was just as severe as the hip and leg pain.

However, the neurological exam did not show any reflex change. He had allegedly decreased sensation in the right S1 dermatome. Dr. proposed that the patient have a posterior L5-S1 decompression, fusion and instrumentation.

There were two utilization reviews request reports, one by Dr. (M.D.) which was a denial of the requested procedures. The second one was done by Dr. (M.D.) on March 24, 2011, after an appeal had been completed by Dr..

The rationale for Dr. denial included the lack of compliance with the ODG. It was also noted that the patient's response to the nonoperative care noted that there was inadequate documentation of conservative management. There were no therapy progress notes allegedly submitted for review.

The denial per Dr. noted that there was no clear documentation of associated findings with relevant reflexes, muscle weakness or atrophy that would correlate and would support the need for a decompression of L5-S1.

The request as submitted is not consistent with the ODG criteria for lumbar fusion. The patient has not had any spine instability demonstrated. There are no progressive neurological deficits. There is no indication of any fracture. The patient's psychological assessment has not been completed. The patient's ability to return to a different type of work or that type scenario was not discussed. The evidence based medicine would not support the progression of care to a decompression and fusion operation at L5-S1 in this scenario. Thus the denial is upheld.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
 - ODG – TWC low back