

MATUTECH, INC.

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

Notice of Independent Review Decision

DATE OF REVIEW: January 26, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral lumbar hardware block at L3-L4 and L4-L5

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

Board Certified, American Board of Neurological 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

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported back pain on xx/xx/xx, after xxxxx

On October 21, 2009, , M.D., obtained computerized tomography (CT)-myelogram of the lumbar spine that revealed: (1) A left laminotomy and interbody and healed, confluent posterolateral fusion at L5-S1. The right L5 pedicle screw extended ventrally beyond the discovertebral margin. (2) A 3-4 mm left-sided disc herniation at L3-L4 producing moderate ventral dural deformity at the foramen level leaving 6-7 mm residual midsagittal dural diameter. There was also bilateral dorsolateral impingement on the dural sac due to posterior element hypertrophy and bilateral mild foraminal encroachment, worse on the left. (3) Disc degeneration with degenerative anterolisthesis exacerbated in flexion at L4-L5. (4) Advanced disc degeneration at L1-L2 with anterior spondylosis and a left paracentral 2-mm hard and soft disc protrusion and a bulge at L2-L3.

On November 5, 2009, Dr. performed a right-sided epidural steroid injection (ESI) at the L3-L4 level.

Psy.D., performed a pre-surgical psychological evaluation. Mr. opined that there were no contraindications for spinal surgery. However, he recommended a brief course of individual psychotherapy as the patient was dealing with significant feelings of depression, anxiety, frustration, irritability and feelings of worthlessness.

On March 19, 2010, Dr. noted the following treatment history: *"The patient was status post lumbar laminectomy by Dr. on March 19, 2007. He had recurrent pain in 2004 and had a lumbar fusion by Dr. which helped. He had low back and bilateral leg pain. He developed a grade 1 spondylolisthesis at L4-L5 with gas vacuum phenomenon in both facets. The right L5 pedicle screw was in the anterior aspect of the L5 vertebral body. The left L5 pedicle screw was in good position. The L5-S1 fusion was solid. There was a ventral dural defect at L3-4 with bar defects and diminished filling bilateral, left greater than right. He had developed a functional syndrome above the L5-S1 fusion. He was a candidate for L3-L4 and L4-L5 decompression and fusion. He had failed conservative therapy including ESI, physical therapy (PT), home exercise program (HEP), and job restrictions. This was deferred due to the fact that he had bilateral total knee replacements by Dr. on December 28, 2009. He had rehabbed his knees and would like to proceed with surgery. Examination revealed well-healed anterior scars on both knees. Straight leg raise (SLR) was positive bilaterally at 60 degrees producing ipsilateral low back pain. Dr. diagnosed L3-L4 stenosis with facet and ligamentous hypertrophy producing par defect, bilateral lateral recess stenosis, grade-1 L4-L5 spondylolisthesis, facet hypertrophy and gas vacuum phenomenon/lipomatosis and junctional syndrome and status post L5-S1 instrumented fusion. He recommended decompression and fusion at L3-L4 and L4-L5.*

From June 7, 2010, through August 13, 2010, the patient attended 23 sessions of PT consisting of heat/ice application, ultrasound and electrical stimulation.

On November 8, 2010, x-rays of the lumbar spine showed postoperative changes from total lumbar interbody fusion extending from L3 through S1. The instrumentation appeared to be intact and unchanged.

On November 22, 2010, M.D., performed a peer review and noted the following treatment history:

1996: *On xx/xx/xx, the patient was evaluated in the emergency room. X-rays of the lumbar spine were unremarkable. The assessment was acute lower back pain and previous back injuries including back giving out three to four times a year. On xx/xx/xx, MRI scan of the lumbar spine reported: (1) A mild eccentrically located disc protrusion (small possible disc herniation) at L1-L2. (2) Mild central disc protrusion with annular fissure at L4-L5. (3) Mild central disc bulge at L3-L4. (4) Mild degenerative disc disease (DDD) at L2-L3, L4-L5, and L5-S1. The patient then underwent physical therapy. On September 22, 1996, the patient was evaluated by Dr. with subjective complaints of pain in the right buttock and thigh. The patient was prescribed Elavil. On August 12, 1996, the patient underwent a series of three epidural steroids by Dr.. On September 6, 1996, a CT postmyelogram study reported L4-L5 disc degeneration with minimal*

narrowing but moderate annular bulging without evidence of herniation or stenosis with conjoint origin of the L5 and S1 nerve root sleeves. On December 6, 1996, the patient underwent a neurosurgical evaluation by Dr. which stated the patient was not a surgical candidate for L3-L4 discectomy. CT scan of the lumbar spine on January 17, 1997, reported: (1) Disc herniation at L1-L2 pushing left side of the thecal sac extending to the left foramen. (2) Broad-based bulge or disc protrusion at L5-S1. (3) Soft tissue appeared to be causing moderate narrowing at L5-S1 foramina bilaterally with a small bulge centrally at L4-L5 and to a lesser extent L3-L4.

1997: On March 14, 1997, the patient underwent a lumbar hemilaminectomy, foraminotomy, and partial inferior fasciectomy removal extruded discs and lumbar hemilaminectomy, foraminotomy exploration at L4/5 and L5/S1 levels. The patient underwent a psychiatric evaluation with the assessment of major depression without psychotic features in partial remission and chronic pain syndrome. The patient was given a prescription of Zoloft. On September 4, 1997, Dr. assessed maximum medical improvement (MMI) with 11% impairment rating.

1998: On March 9, 1998, MRI scan of the lumbar spine reported post L1-L2 discectomy and degeneration of all discs with very minimal bulging. From June through July 1998, the patient underwent a chronic pain management program (CPMP).

On November 9, 1998, MRI scan of the lumbar spine reported postoperative changes at L1-L2 and L4-L5 with no evidence of focal recurrent disc protrusion and mild multilevel disc bulges.

2003: MRI scan of the lumbar spine demonstrated evidence of recurrent disc at L5-S1 level on the right and midline herniated disc at L4-L5. In 2003, Dr. assessed herniated disc and recommended steroid injections. On September 20, 2004, the patient underwent laminectomy at L5 with bilateral inferior fasciotomies of L5, decompression of cauda equina, decompression of conjoined nerve roots with wide foraminotomy, lysis of external adhesions around S1 nerve root on the right, removal of recurrent disc herniation, total discectomy and interbody fusion at L5-S1 with P cage by Dr..

2007: The patient underwent neurological evaluation by Dr.. The patient had subjective complaints of low back and left leg pain. ROM of the lumbar spine was decreased. Sensory examination revealed hyperesthesia to pinprick in the right foot. The assessment was low back pain and left leg pain and post-laminectomy syndrome.

CT scan of the lumbar spine reported: (1) L5-S1 fixation appeared confluent with protrusion of tips of the left S1 and right L5 fixation screws beyond the discal convertible margins and epidural scarring. (2) A right-sided 2 to 3 mm disc herniation at L3-L4 and vacuum phenomena at L1-L2 discs. X-rays reported minimal bony effusion, L5-S1 was anatomic position, and the status of the bony fusion were unproven.

2009: On February 6, 2009, the patient underwent bilateral lumbar facet blocks at L3-L4 and L4-L5. On August 14, 2009, the patient underwent lumbar facet rhizotomies at L3-L4 and L4-L5. The patient reported 60% pain relief after the rhizotomy. On April 30, 2010, the patient was status post L3-L4 and L4-L5 decompression and fusion with posterior instrumentation.

2010: On September 22, 2010, the patient followed up with Dr. with subjective complaints of a painful rash. There was an erythematous cluster or papules on the right flank. Straight leg raising (SLR) was positive bilaterally at 80 degrees. Motor strength was 5/5 in all major groups. The impression was residual lower

back pain status post decompression and fusion and posterior instrumentation, possible withdrawal syndrome and probable herpes zoster. The patient was a prescription for acyclovir and Neurontin. On October 22, 2010, a letter from Dr. stated the patient developed herpes zoster as a reaction to steroids. Therefore, this was related to his work-related injury of July 11, 1996.

Dr. opined as follows: (1) The current working diagnosis as causally related to the compensable injury of xx/xx/xx, was postlaminectomy syndrome status post recent L3-L4, L4-L5 spinal decompression and fusion. (2) The recently reported diagnosis of herpes zoster was not directly related to the compensable injury. (3) The Official Disability Guidelines (ODG) would support follow-up with treating physician every three to four months and occasional x-rays of the lumbar spine. The medication regiment was not reasonably required to address the sequelae of the compensable event.

On February 11, 2011, x-rays of the lumbar spine showed: (1) Advanced degenerative disc space loss noted at L1-L2 and L2-L3. The degree of disc space loss at L2-L3 appeared worse when compared with previous examination. (2) Postoperative changes from total lumbar interbody fusion noted from L3 through S1. There appeared to be solidly healed bone graft material bilaterally.

In October, 2011, Dr. evaluated the patient for low back pain. He reported he was getting a new grandson and had been doing more lifting and bending. Dr. diagnosed exacerbation of lower back pain and residual low back pain status post L3 to L5 fusions with posterior instrumentation. He prescribed Medrol Dosepak and Robaxin. On follow-up, Dr. noted diffuse tenderness in the lower lumbar area and peri-incisional area, left greater than right; positive Patrick's, pelvic rock test and Flamingo tests; tenderness over the left SI joint area. Flexion and extensions views of the lumbosacral spine showed severe disc space narrowing at L1-L2 and L2-L3 with slight retrolisthesis on extension at L2-L3. The screws, rods and grafts appeared in anatomical position and L3 to S1 appeared solid. Dr. diagnosed possible painful lumbar instrumentation and possible left sacroiliitis and recommended lumbar instrumentation block.

Per the utilization review dated November 3, 2011, the request for L3-L4 and L4-L5 facet blocks was denied.

Per the utilization review dated November 8, 2011, the request for L3-L4 and L4-L5 hardware block was denied based on the following rationale: *"The claimant did not have diagnostic evaluation of a failed lumbar spinal surgery syndrome. Guidelines indicate injection procedures are to be performed on claimants who have undergone fusion where hardware was determined to be the continued source of the claimant's pain. There was no documentation of physical examination findings or imaging suggesting a failed lumbar spinal surgery."*

In December, Dr. appealed for lumbar instrumentation block. He stated that the patient was tender in the peri-incisional area which is the area of the lumbar instrumentation surgery. On follow-up, Dr. reported that on the recent examination of December 1, 2011, the patient was tender over the lumbar instrumentation. He requested for lumbar instrumentation block to know the evidence of failed spinal surgery other than the patient's tenderness and pain over the instrumentation.

Per the reconsideration review dated December 21, 2011, the request for L3-L4 and L4-L5 hardware block was denied based on the following rationale: *“The patient has had no treatment attempted for flare-up of low back pain beginning September 2011. Fusion was reported as solid by x-ray with no evidence of hardware failure. Patient’s exam was not focally positive over hardware alone. There is sacroiliac tenderness as well. Facet blocks were recently appropriately denied for these identical symptoms. Request now for hardware blocks is not reasonable or necessary.”*

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

Records to be reviewed: Summary by Matutech and the final summary done in very great depth by Dr. M.D.

This is a gentleman who is now about, born in xxxx who had an injury about four years ago.

He had back and leg pain and was worked up and conservative measures were tried and subsequently the gentleman underwent the surgery by Dr..

Following surgery at L4-L5, he continued to have difficulty and subsequently a fusion was performed at that same level again by Dr.

Subsequently, the patient did fairly well; however, had another exacerbation with the fusion being solid of L5-S1. He had some progressive difficulties and L3-L4 and L4-L5 were noted to be significantly degenerated by MRI and other studies with degenerative herniated disc.

Subsequently, Dr. stabilized those two motion segments.

Apparently they healed very nicely as documented by the imaging studies. Prior to the surgery, the patient was evaluated by, neuroradiologist with a myelogram/myelogram-CT. Dr. did neuropsychological testing and felt the patient was a good candidate.

Subsequently, the patient continued to have difficulty and Dr. and his PA continued to follow the patient. Medications and therapy of all sorts were tried. Studies were repeated and the patient was felt to need possibly the hardware removed. The imaging studies and flexion/extension films show that the fusion is solid and there is no motion at the L3-L4, L4-L5 and L5-S1 segments and on several occasions, Dr. has been denied approval for removal of the prior hardware.

Apparently, the ODG guidelines have been quoted and rightly so that there has been no demonstrable instability or any documented testing, etc., that the hardware is painful. The hardware is in place radiographically and the fusion is solid radiographically and with flexion/extension films and therefore, an appeal of the denial was again upheld and the denial is valid.

The patient currently is still under the care of Dr. for his back. He has gone through courses of conservative therapy at Dr. request and has continued to have complaints.

Facet rhizotomies were done at L3-L4 and L4-L5 in August 2009 with significant relief. This was prior to the stabilization of those two motion segments.

As carefully documented by Dr. in his November 22, 2010, summary, the medications and requests for medical care have been gone over thoroughly and some approved, and as stated above, some have not been approved.

The records that were reviewed are the Employee's First Report of Injury of the xx/xx/xx, incident. Hospital, Dr., Dr. P., osteopath, and Dr., osteopath, Dr.. Dr.. Dr., D.O., osteopath, Dr. D.O., Dr., reviews by Dr., notes by Dr., and medical notes by Dr., Dr., Dr., Dr., numerous laboratory reports, Dr., and Dr. as well as the therapy notes from Hospital.

The bilateral lumbar hardware block at L3-L4 and L4-L5 is not necessary on this gentleman as he is asymptomatic. In conclusion, the previous denials are valid.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES