

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: May 30, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient posterior lumbar decompression and fusion at L5-S1 x3 days LOS 63047, 22612 and 22851

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

- Reviews (01/04/05 – 06/11/10)
- Diagnostics (10/31/06 - 08/19/11)
- Office visits (11/06/09 - 04/17/12)
- Utilization reviews (04/04/12 – 05/07/12)

Dr.

- Diagnostics (05/08/03 - 08/21/11)
- Office visits (07/23/04 - 04/17/12)

TDI

- Utilization reviews (04/04/12 – 05/07/12)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was xx years of age on xx/xx/xx, when he had an injury to the hip area with laceration when he was struck on the right side and pushed up against another box. He subsequently had a bone scan on May 8, 2003, showing some increased uptake with possible osteoblastic activity in the left anterior superior iliac spine as well as the left superior pubic ramus.

The patient has undergone multiple MRIs over his course of treatment including original 2004 MRI which by report showed L3-L4 to have a central disc osteophyte protrusion while at L4-L5, there was a small left paramedian disc protrusion with bilateral facet hypertrophy and at L5-S1, there was a small central disc osteophyte protrusion superimposed upon a mild diffuse disc bulge. There was also some mild lateral recess stenosis. The patient was followed by Dr. who performed an epidural steroid injection at L4-L5 with reported 50% relief of the leg pain but inadequate relief of the back pain. The patient also had subsequent facet injections in February 2005, which provided incomplete relief. A discogram of the L3-L4, L4-L5 as well as control level L2-L3 was performed on April 12, 2005. Dr. reported concordant pain at L3-L4 and L4-L5; they were unable to get into the L5-S1 segment and the L2-L3 was considered normal.

Dr. proposed endoscopic surgery at L3-L4 and L4-L5 which went through multiple levels of dispute. Apparently it was approved, although I do not have an operative report of these two levels having surgical intervention subsequently.

The patient in 2007 had request for the L5-S1 decompression and fusion and an IRO was to be submitted although that was not forwarded in the paperwork.

On November 17, 2008, the electrodiagnostic study was performed by Dr. which was unremarkable and no distinct radiculopathy was reported.

There was another MRI completed on November 21, 2008, which was interpreted by Dr. to show fissuring of the annulus at the posterior aspect of the L3-L4 disc with an L4-L5 broad-based disc bulge with degenerative facet causing some mild right-sided neural foraminal stenosis and moderate left-sided neural foraminal stenosis. There was an L5-S1 central disc protrusion with underlying disc bulge. There was no report of any spondylolysis or spondylolisthesis.

On November 6, 2009, Dr. proposed that the patient would be a candidate for the X-lift of the L3-L4 and L4-L5 discs to help with the patient's symptoms.

On February 5, 2010, Dr. proposed the diagnosis now of spondylolisthesis at L5-S1 with 4-mm shift at this level.

On March 5, 2010, Dr. reports that the patient wanted to proceed with a surgical correction at L5-S1.

The patient had a designated doctor examination with Dr. (M.D.) on June 11, 2010, who remarked that the patient would be a candidate for further care of his lower lumbar complaints.

On October 2, 2010, Dr. reported that the patient's spondylolisthesis was secondary to injury to the facets.

On November 5, 2010, Dr. diagnosed lumbar spondylolytic spondylolisthesis which indicates that there was a spondylolysis as a basis for the spondylolisthesis which appears inconsistent with the previous report.

This diagnosis was continued on by Dr.. On July 11, 2011, Dr. now states that there is a grade I L3-L4 spondylolisthesis as well as the L5-S1 spondylolytic spondylolisthesis.

On August 21, 2011, another MRI was completed and read by Dr. (M.D.) at Imaging Center. He noted there was osteophytic ridging with a broad central 5-mm disc protrusion with mild canal stenosis but no neural impingement at L5-S1. At L4-L5, there was moderate facet arthrosis with mild canal stenosis. There was also a 3-mm central disc protrusion at L4-L5. At L3-L4, there was a shallow central disc protrusion not impinging on the canal or the traversing neural element. There was mild facet arthrosis. L2-L3 also had mild facet arthrosis without focal protrusion.

Dr. however reported on August 28, 2011, that the L5-S1 broad disc bulge resulted in moderate spinal canal stenosis. There was also left lower extremity pain greater than right.

The patient was further submitted for surgical intervention with utilization review being completed.

Dr. stated that the patient was psychologically cleared to proceed with the recommended surgery without reservations.

Per the utilization review regarding the L5-S1 decompression and fusion surgery was denied through the preauthorization process. The patient has then been submitted for an IRO assessment.

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

Given the totality of these records that date back to 2003, this patient has had discogram-proven L3-L4 and L4-L5 concordant pain and has obvious disc abnormalities at those levels. The proposed L5-S1 surgical intervention was not confirmable on discogram as it was never performed at that level. There is also no independent validation that there is an L5-S1 spondylolytic or even degenerative facet disorder spondylolisthesis present. Moreover, there is no significant canal stenosis or neurological deficit as the electrodiagnostic study did not show any specific neurological deficit.

There is inconsistency in the report by Dr. regarding the nature of the spondylolisthesis at L5-S1. However, any fusion at L5-S1 will be building on the foundation of L4-L5 and L3-L4 which had already been shown by Dr. (if one were to accept the discogram result as valid) to be abnormal. Thus, the patient may not be helped at all with any type of surgical intervention at L5-S1 to include a fusion surgery. The ODG would not support a multilevel fusion or the fusion as proposed given these clinical scenario. Thus the request is denied as a medical necessity and the previous preauthorization reviews are 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**