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Notice of Independent Review Decision

Date: October 21, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient L5-S1 anterior/posterior fusion with bone graft harvest 22612, 22840, 20938 and 22558 with 1-2 day LOS.

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

Orthopedic Surgeon
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:

- Utilization reviews (08/28/13, 09/27/13)
- Office visits (10/06/11 - 08/02/13)
- Diagnostics (01/27/12, 04/26/13)
- Utilization reviews (08/28/13, 09/27/13)
- Letter (09/06/13)
- Office visits (10/06/11 - 08/02/13)
- Diagnostics (01/27/12, 04/26/13)
- Letter (09/06/13)
- Utilization reviews (09/27/13)

ODG criteria has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is male who on xx/xx/xx, sustained injury to the low back.

2011: On October 6, 2011, the patient saw for low back pain with intermittent stabbing feeling. The patient's symptoms increased with increased activity. It was noted that the patient had undergone treatment at an emergency room (ER). His previous treatment consisted of a magnetic resonance imaging (MRI) and medications. assessed sprain of the lumbar spine and recommended supervised physical therapy (PT) three times a week for four weeks with modalities including ultrasound, electrical stimulation or iontophoresis. The patient was placed on light duty with restrictions.

On October 24, 2011, performed a designated doctor evaluation (DDE). The following treatment history was noted: *The patient was injured at work. He was seen on July 20, 2011. A MRI dated July 25, 2011, showed mild degenerative changes in the lumbar spine with no evidence of disc protrusion or soft tissue strain. The patient was followed up on July 28, 2011, and was given exercises for his back. He was followed up again on August 5, 2011, and his diagnosis was lumbar strain. The patient was followed up and was prescribed PT on August 25, 2011, and had received at least three treatments. This helped somewhat. The patient was prescribed hydrocodone, Flexeril and methylprednisolone. His last PT was in September.*

assessed maximum medical improvement (MMI) as of September 6, 2011, with 5% impairment rating (IR). He felt that the patient had some lumbar strain with some degenerative changes. The MRI did not reveal anything significant other than degenerative changes. The patient continued to have some pain. He was probably suffering from some long-term degenerative lumbar problems.

On November 4, 2011, noted that patient's symptoms were worse by walking, lifting, twisting, going up stairs, coughing and sneezing. He also noted that PT had not yet been approved. He recommended supervised PT and light duty.

2012: On January 9, 2012, noted that the patient had worsening of his pain as a result of a fall four days ago. His low back pain increased with increased activity. It was noted that PT had been denied. recommended supervised PT and light duty with restrictionsa. MRI was ordered.

On January 27, 2012, MRI of the lumbar spine showed the following findings: (1) Degenerative disc disease (DDD) with disc desiccation, loss of disc height and redundancy and bulging of the annulus fibrosis. The conus ended at L1. (2) At L2-L3, a slight redundant bulging annulus and facet hypertrophy. (3) At L3-L4, a broad 3-mm disc protrusion with a more prominent 4-mm right foraminal/far lateral component, ligamentum flavum redundancy and facet hypertrophy resulting in mild central and lateral spinal stenosis. Bilateral anterolateral and subarticular recess narrowing with impingement upon the L4 and exiting L3 nerve roots. The right side was slightly more affected than the left. (4) At L4-L5, a broad 4-mm disc protrusion with a more prominent 5-mm right foraminal/far lateral component, ligamentum flavum redundancy and facet hypertrophy resulting in mild central and

lateral spinal stenosis. Bilateral anterolateral and subarticular recess narrowing with impingement upon the L5 and exiting L4 nerve roots. (5) At L5-S1, a redundant bulging annulus and 3-mm right foramina/foraminal disc protrusion were present. A small right foraminal annular fissure was seen. Bilateral subarticular recess narrowing was seen with impingement upon the exiting L5 nerve roots.

On February 1, 2012, noted that PT had not yet been approved. He reviewed MRI which showed stenosis at L3-L4 and L4-L5. assessed sprain of the lumbar spine and lumbar spinal stenosis and recommended PT for core strengthening and modalities. The patient was referred to a pain management specialist for possible epidural steroid injection (ESI).

On February 20, 2012, saw the patient for low back pain radiating into the left lower extremity. The pain was sharp, shooting, stabbing, aching, burning and constant in nature. The patient reported weakness, numbness and tingling in the left lower extremity. Examination showed positive straight leg raise (SLR) bilaterally and sensory deficit in the left L5 dermatome. recommended lumbar ESI.

On February 27, 2012, performed a lumbar ESI at L5-S1. Diagnoses were lumbar strain, lumbar herniated nucleus pulposus (HNP) and lumbar radiculitis.

On March 2, 2012, noted that the patient had slight improvement with ESI. He recommended PT and light duty.

On March 6, 2012, noted that the patient had an overall improvement in pain by less than half. recommended observation.

On May 25, 2012, evaluated the patient for low back and leg pain. It was noted that the patient had attended PT in August 2011 with no improvement. The patient had undergone injection but with no benefit. His pain level was 7/10. The back pain was worse on sitting. It occurred primarily at the base of his spine, although symptoms were somewhat diffusely distributed. The patient was also experiencing leg pain rated as 7/10. The patient had fallen several times because of his leg giving out and pain in his leg. He was unable to work due to the pain. He had significant discomfort while seated. He ambulated with a flexed position and moved slowly in an antalgic way. He had difficulty standing on the toe of his left foot due to leg pain. He had tenderness at L5-S1 and to a lesser extent at L3-L4 and L4-L5 in the midline. The muscles were extremely tight and perhaps in mild spasm. Sensation was subjectively diminished in a left L3, L4, L5 and S1 distribution. reviewed MRI of the lumbar spine. He stated that the patient's pain seemed to be primarily focused on the base of the spine and his leg symptoms were primarily in an L5 distribution. He recommended nonsteroidal anti-inflammatory medication and continuing exercises. A discogram of the lumbar spine with post discographic Marcaine challenge was recommended if there was no improvement.

On June 22, 2012, noted that the patient continued to have constant pain. The patient had seen who recommended meloxicam. He continued to have back and leg pain rated as 9/10. Examination showed tenderness at the base of the spine and diminished sensation in the left L5 and S1 distribution. stated that the patient had back and leg pain that correlated to the L5-S1 segment where it was slightly desiccated with degenerative changes. prescribed meloxicam and recommended exercises and considering a repeat ESI and/or discogram if the patient continued to have pain.

On July 27, 2012, noted the patient had tried meloxicam but he continued to have persistent pain. He was doing home exercises but with no improvement. He continued to have back pain as well as pain in the left L5 distribution. recommended left L5 transforaminal ESI. He recommended proceeding with a discogram to include a negative level and Marcaine challenge with a post-discographic CT scan. The patient was to return for follow-up after completing his workup with his pain doctor.

On August 27, 2012, performed a lumbar nerve root block at the left L5 level.

On September 14, 2012, noted that the patient had two injections with temporary relief lasting for three to four days. His pain had returned and it was unchanged. He had pain going into both legs; however, the left leg was worse. The pain extended down to the top of the foot and toes. He had noted that his toes cramped on him frequently. His leg was feeling weak on sitting for prolonged period of time, and his leg was unstable when he attempted to stand. He reported falling on several occasions. He had failed non-operative care. At a minimum, the patient would require decompression and fusion of the L5-S1 segment to address his current complaints. recommended a discogram of the L4-L5 segment to identify whether it was a pain generator. If the discography at the L4-L5 was positive, then a discogram at L3-L4 should be obtained for a negative control. If the L3-L4 was negative but L4-L5 was positive, then L4-L5 segment needed surgical procedure. recommended either a walker or a cane.

On October 16, 2012, noted that the patient had been to the ER due to pain as it was bad and he could not walk. He was using a walker. The patient was pending approval for a discogram.

On October 19, 2012, noted that discogram had not yet been approved. The patient was miserable and in pain. recommended follow-up after discogram.

On December 7, 2012, the patient reported ongoing back pain that went down his leg and worse on the left. The pain was extending down the anterior thigh, shin and into the foot. Pain made it difficult for him to do different activities. Request for lumbar discogram was denied. was concerned that the patient might have neurologic impairment with weakness in the leg. Examination showed point tenderness in the lumbar spine at L5-S1 and to some extent at the levels above as well. recommended obtaining a discogram.

2013: On February 8, 2013, noted ongoing back and left leg pain extending the leg into the foot. The patient was miserable. He had tenderness at the waistline and at the base of the spine. He was able to sit and stand for 30 minutes before he had to sit and change positions. stated that the patient had L4-L5 and L5-S1 disc herniation with a right paracentral protrusion at L4-L5 and impingement on the L4 and L5 nerve roots. At L5-S1, the patient had a bulging annulus with foraminal stenosis and a small tear as well. recommended proceeding with an L5-S1 anterior/posterior fusion. The patient was to follow-up after the approval of the discogram.

On April 26, 2013, x-rays of the lumbar spine showed mild disc narrowing at L4-L5 and small unfused apophysis off the anterior/superior L2 endplate.

On May 3, 2013, noted that previously requested discogram to assess whether the L4-L5 disc was contributing to the patient's pain was denied. There was no other choice left but to proceed with a request for a one level fusion. recommended that the patient's surgery be reviewed again.

On July 22, 2013, saw the patient for initial psychiatric evaluation and stated that there was no contraindication for spinal surgery. He recommended cardiology consultation with electrocardiography (EKG) and stress preoperatively due to questionable history of two myocardial infarctions.

On August 2, 2013, reviewed a letter dated May 21, in which he had denied the requested services. cited the reasons for his denial as there being no evidence of nerve root compression noted at the base of spine. He also noted that no psychological testing had been performed. appealed for denial of the requested services. The tests that had been requested in order to confirm the diagnosis of symptomatic internal disc disruptions at L5-S1 and a possible nerve root compression at L4-L5 had been repeatedly denied. The patient was unable to work due to the degree of pain he had, which appeared to be structural in nature and correlated with the findings on radiographic studies and physical exam. He did not have a lumbar strain injury. He had internal disc disruption and disc herniation which were the source of his current pain. requested approval for the requested services or even better for a lumbar discogram to confirm the diagnosis.

Per utilization review dated August 28, 2013, the request for L5-S1 anterior/posterior fusion with bone graft harvest 22612, 22840, 20938, and 22558 1-2 day LOS was denied, with the following rationale: *"The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The mechanism of injury is noted to be lifting. Medications currently prescribed for the patient were not provided in the medical records. Surgical history of the patient was not provided in the medical records. Diagnostic studies include x-rays of the lumbar spine completed on October 10, 2012, which revealed mild degenerative disc disease, nonspecific bilateral abdominal calcifications, more so on the right side, and no bony abnormalities. The patient also underwent an MRI on January 27, 2012, which revealed degenerative disc*

disease with disc protrusions at L3-L4, L4-L5 and L5-S1 as well as osteoarthritis and spinal stenosis at L3-L4 and L4-L5. Furthermore, imaging revealed anterolateral and subarticular recess narrowing with nerve impingement. Moreover, at the specified level for the requested surgery noted a redundant bulging annulus and 3 mm right foraminal/foraminal disc protrusion as well as a small right foraminal annular fissure with no spinal stenosis present and bilateral subarticular recess narrowing with impingement upon the exiting L5 nerve roots. Other therapies for the patient have included an unknown number of sessions of physical therapy as well as two epidural injections and activity modifications as well as medication management. This patient is a male who reported an injury on xx/xx/xx. The current request is for an L5-S1 anterior/posterior fusion with bone graft harvesting and a 1 to 2 day hospital stay. The documentation submitted for review indicates that on imaging the patient has evidence of a redundant bulging annulus and 3 mm right foraminal disc protrusion as well as evidence of a small right foraminal annular fissure with bilateral subarticular recess narrowing and impingement upon the exiting L5 nerve roots. However, there is no spinal stenosis present at the L5-S1 level. Notes indicate that the patient has undergone treatment with conservative measures to include an unknown number of sessions of physical therapy as well as two epidural injections with no significant benefit, and the patient remaining symptomatic. Also, the documentation submitted for review indicates on physical examination that the patient presents in significant discomfort and walks with his back slightly flexed and moves slowly due to pain. The notes indicate the patient to have localized tenderness which is indicated as diffusely distributed in the low back and extends from the waist down to the base of the spine. The notes indicated that the patient pointed to his waistline to indicate where the pain was at its worst point. Furthermore, notes indicate that strength testing revealed motor strength to be symmetrical in the quadriceps, anterior tibialis and extensor hallucis longus (EHL), with point tenderness in the lumbar spine at L5 and S1 and to some extent at the level above. The notes indicate subjectively that the patient states he is only able to stand or sit for 30 minutes before he has to sit and change positions. Furthermore, notes indicate that the patient had sensory changes in an L5 distribution. The documentation submitted for review indicates that the patient completed a psychiatric evaluation and received clearance. However, that evaluation was not provided in the medical records. Moreover, there is a lack of documentation of instability of the spine at the requested level. The imaging submitted for review showed a redundant bulging annulus and 3-mm right foraminal disc protrusion as well as a small right foraminal annular fissure with no spinal stenosis present and bilateral subarticular recess narrowing with impingement upon the exiting L5 nerve roots; however, no spinal stenosis was noted. There were no x-rays with flexion/extension views revealing instability at the requested level. Given the above, the request for inpatient L5-S1 Anterior/Posterior Fusion with Bone Graft Harvest 22612, 22840, 20938 and 22558 with 1-2 day LOS is non-certified.”

On September 6, 2013, stated that at a minimum the patient needed to have the L5-S1 and L4-L5 segments addressed with a decompression to address his leg symptoms. He recommended considering an L4 to the sacrum decompression and fusion with the decompression being performed on the left side only.

Per reconsideration review dated September 27, 2013, the request for L5-S1 anterior/posterior fusion with bone graft harvest 22612, 22840, 20938 and 22558 was denied with the following rationale: *“The patient is a male who injured his low back on xx/xx/xx. The patient is diagnosed with lumbar spondylosis. An appeal for L5-S1 anterior/posterior fusion with bone graft harvesting and hospital stay has been made. The request was previously denied since the psychiatric evaluation was not provided in the medical records. Also, there was a lack of documentation of instability of the spine at the requested level. There are updated documentations submitted for review including a recent medical record dated September 6, 2013, a July 22, 2013, initial psychiatric evaluation and a April 26, 2013, x-ray of lumbar spine. Lumbar spine MRI of January 27, 2012, revealed degenerative disc disease with disc protrusions at L3-L4, L4-L5 and L5-S1 as well as osteoarthritis and spinal stenosis at L3-L4 and L4-L5. X-rays of the lumbar spine on October 10, 2012, revealed mild degenerative disc disease. The patient was initially treated with medications and physical therapy with no benefit. He also had two epidural injections dated February 27, 2012, and August 27, 2012, which provided temporary relief. X-rays of the lumbar spine dated April 26, 2013, showed mild disc space narrowing at L4-L5. The psychological evaluation dated July 22, 2013, indicated that there was no contraindication to the spinal surgery. The recent medical record dated September 6, 2013, indicated that the patient continues to experience low back pain radiating to the left lower extremity. Physical examination revealed tenderness over L4-L5 and L5-S1. While the patient complains of radiating low back pain, the records submitted for review did not contain specific objective findings such as motor deficits and positive provocative tests to support the diagnosis of lumbar spine radiculopathy. Also, the recent flexion-extension x-rays of the lumbar spine showed no evidence of instability. Moreover, there was no evidence in the medical reports submitted of the patient’s a failure to respond to recent non-surgical treatment modalities such as activity modification, medications, and physical therapy. In agreement with the previous determination, the medical necessity of the request has not been substantiated.”*

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

This patient who had a work injury on xx/xx/xx, complained of low back pain. The first records for review are from October 6, 2011 when he was seen, who noted the patient had been to the emergency department as well as seen by another M.D. although those records were not available. noted that the patient had no radicular pattern and diagnosed sprain of the lumbar spine and proposed supervised physical therapy for up to twelve sessions. The patient was placed on light duty.

On October 24, 2011, a designated doctor exam was completed who noted that the patient had had an MRI completed on July 25, 2011, which only showed mild

degenerative changes in the lumbar spine without evidence of disc protrusion or a soft tissue strain. The patient had been seen at the Urgent Care on July 28, 2011, and had been given exercises for the lumbar spine. The patient had formal therapy per order of Urgent Care which helped somewhat.

noted that the patient had a diagnosis of a lumbar strain with degenerative changes and the patient was awarded 5% impairment rating with MMI date of September 6, 2011.

The next records are from on November 4, 2011, noting that the patient was having increased symptoms with walking, lifting, twisting, coughing and sneezing. He noted that the symptoms were localized to the low back. The patient had not had further formal therapy yet.

On January 9, 2012, reported that the patient had a fall four days previously but no further details were provided. again recommended supervised therapy and light duty and ordered another MRI of the lumbar spine.

On January 27, 2012, the MRI of the lumbar spine was completed at Diagnostics. Per the report, it showed degenerative disc disease with desiccation and loss of disc height and bulging of the annulus fibrosis. The conus ended at L1. There was L3-L4 and L4-L5 disc protrusion with mild central canal stenosis and lateral mild spinal stenosis. There was also disc degeneration at L2-L3 with bulging annulus and facet hypertrophy. At L5-S1, there was redundant bulging annulus and a 3-mm disc protrusion towards the right. A small right annular fissure was reported.

On February 1, 2012, noted that the patient's MRI had shown stenosis at L3-L4 and L4-L5. He proposed diagnoses of lumbar spine strain/sprain as well as lumbar spinal stenosis and the patient was referred for pain management for possible epidural steroid injections. Please note that the neurological exam was noted to be normal.

On February 20, 2012, saw the patient for low back pain radiating to the left lower extremity. The patient now reported allegedly weakness and numbness and tingling in the left lower extremity with exam finding of straight leg raise positive bilaterally. (Reviewer's comment: The radiation if any of the straight leg raise was not defined anatomically as far as extent of radiation). There was also a sensory deficit reported in the left L5 dermatome. proposed a lumbar ESI.

On February 27, 2012, the ESI was completed at L5-S1.

On March 2, 2012, noted that the patient had slight improvement with the ESI.

On March 6, 2012, noted that the pain had nausea and vomiting after the ESI and that the pain had improved by less than half. He proposed further observation.

on May 25, 2012, evaluated this patient for low back and leg pain. He noted that the patient had a attended therapy without improvement and also had undergone injection treatment without benefit. The current pain level was reported to be at 7 on a 10 scale with back pain worse on sitting. Now the discomfort was reported at the base of the spine although there were some symptoms diffusely distributed. The patient was on tramadol. The patient had difficulty standing on the toes of his left foot because of leg pain. The patient was also reported to have decreased sensation subjectively on the left side in the L3, L4, L5 and S1 dermatomes. did review the MRI per his note stating that the patient's leg symptoms were primarily in an L5 distribution and he proposed a discogram of the lumbar spine with postdiscogram marcaine challenge be performed.

The patient was re-assessed on June 22, 2012, who again recommended either a repeat ESI and/or discogram.

On July 27, 2012, the patient had tried meloxicam but continued to have persistent pan. recommended an L5 left-sided transforaminal ESI as well as a discogram be done.

On August 27, 2012, the patient had a selective nerve root block done. He only had short term relief of three to four days per the September 14, 2012, note Please note that noted that there was diffuse tenderness from the waist down.

noted that the patient had failed non-operative care and would require decompression and fusion of the L5-S1 segment. He proposed a discogram again for L4-L5 and also then a L3-L4 discogram for a control level.

on October 16, 2012, noted that the patient had been to the emergency room because of back pain and "inability to walk." He was using a walker on presentation.

On October 19, 2012, noted that the discogram had not been approved.

noted that the patient on December 7, 2012, had ongoing back pain that went into the leg worse on the left. The patient had point tenderness of the lumbar spine allegedly at L5-S1 but also to some degree at the levels above. again recommended a discogram.

On February 8, 2013, reiterated his analysis of the MRI stating that L4-L5 and L5-S1 had disc herniation with right paracentral protrusion at L4-L5 and impingement on the L4 and L5 nerve roots. now proposed proceeding with an L5-S1 anterior posterior fusion.

On May 3, 2013, after denial of the discograms by preauthorization proposed proceeding with surgery at L5-S1.

The patient had a psychiatric assessment who apparently found no contraindications for spine surgery.

proposed and wrote a letter on August 2, 2013, that the patient have the requested services performed including the discogram.

The patient's preauthorization review was then completed who denied the proposed L5-S1 anterior posterior fusion. proposed reconsideration of this denial noting that the patient would at a minimum need to have the L5-S1 and L4-L5 segments addressed with decompression to address the leg symptoms. This note was authored on September 6, 2013; however, the reconsideration performed on September 27, 2013, was a request for L5-S1 anterior posterior fusion which was subsequently denied. No further records are available for review.

Synopsis: The patient has had a designated doctor exam which noted a lumbar sprain/strain without radicular pattern. The patient has multilevel degenerative changes. The MRI done initially apparently just showed degenerative change without nerve root entrapment. The second MRI showed more changes towards the right side but mild central stenosis at L3-L4 and L4-L5. The patient had left-sided symptoms. These records do not clearly define an objective neurological pattern. The proposal of doing a fusion at L5-S1 with noted pathology of the lumbar spine of a significant degenerative nature at L4-L5 and L3-L4 would likely be exacerbated by the fusion at L5-S1. Moreover, the patient's pain appears to be more diffuse than just the L5-S1 level. Thus the patient's need for surgical intervention to include an anterior posterior fusion at L5-S1 is not consistent with the ODG as the patient does not have any spine instability documented and there is no evidence of the patient having focal deficits at only the L5-S1 level. Thus the request as submitted is not approved as a medical necessity.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
Reference ODG-DWC Low Back