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Notice of Independent Review Decision

**Date: December 23, 2013**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Three day inpatient stay; laminectomy, posterior non segmental instrumentation, combined fusion, posterolateral fusion with posterolateral interbody fusion L4-L5, posterolateral fusion 63047, 22840, 22633

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

Diplomate 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:**

- Utilization reviews (10/07/13, 10/23/13)
- Office visits (05/07/13 - 10/02/13)
- Diagnostics (05/10/13, 08/09/13)
- Procedure (05/30/13)
- Physical therapy (06/19/13 – 08/05/13)
- Utilization reviews (08/20/13 - 10/16/13)
- Peer review (11/19/13)
- Prospective IRO review response (12/09/13)

**ODG criteria have been utilized for the denials.**

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who on xx/xx/xx, pivoted and lifted and felt pain. He was able to walk after the event but his back was hurting.

On May 7, 2013, evaluated the patient for low back pain. The patient stated that he was able to walk after the event. However, he stated that his back was hurting. He did not really pay it a lot of attention. When he got home that night, he felt like he could not walk. The next day he was seen by a chiropractor and they did a small adjustment. He stated that he continued to have pain, so he called the chiropractor again and then on April he underwent acupuncture treatments for his back pain. On April 20, 2013, he stated that he noticed blood in his urine. He had no idea if the blood was from the acupuncture or an illness. He saw his primary care provider on April 22, 2013, where he was treated for the hematuria and back pain. He had reported all that to his employer about that time when it was realized that it was a work-related event. He had also seen his primary care provider on April 3, 2013, who treated him for the hematuria but stated they could not treat him for the back pain. The patient stated that he could not sit straight. His calf muscle was cramping. The ankle hurt and it felt cool to touch. He had pain that went from the back of his leg to the foot. It pretty much covered the entire portion of the foot although the great toe seemed to have the most pain. The patient stated that the hematuria seemed to be going away. The patient walked with a stooped antalgic gait and used a cane to walk with. On palpation of the back musculature, the patient had point tenderness at the L5-S1 musculature extending into the buttocks on the left side. He was able to step up on the exam room table step but he had problems doing that. He was not able to perform straight-leg raises (SLR) on the right, because he said it hurt his back too much, and that was while he was sitting. He was able to perform SLR on the left to approximately 30 degrees, until he had shooting pain that went down the leg. The patient was not able to walk on his tiptoes, or walk on his heels, because the pain was too much. Ms. diagnosed back strain with radiculopathy, recommended continuing Norco, Skelaxin and tramadol, starting home therapy and ice application followed by heat, followed by stretching exercises and ordered magnetic resonance imaging (MRI) of the low back. The patient was placed off work.

On May 10, 2013, MRI of the lumbar spine showed left central disc protrusion, most prominent in the subarticular zone at L4-L5, which impinged the traversing left L5 nerve root and minimal disc bulge at L5-S1 with associated central annular fissure.

On May 14, 2013, evaluated the patient for constant lower back pain. The patient reported intermittent radiation of pain into the left lower extremity which was the posterior surface of the thigh and calf. He reported numbness to the anterior surface of his left foot. Examination of the back revealed a negative SLR, seated and supine on the right, positive seated and supine on the left. His gait was antalgic. He ambulated flexed forward at the waist tilted to his left with a cane. reviewed MRI of the lumbar spine and diagnosed low back pain with suspected left L5 radiculopathy. He prescribed gabapentin, recommended discontinuing

Skelaxin and continuing Norco and naproxen. He also recommended consulting interventional radiology for selective nerve root injection.

On May 21, 2013 noted that the patient was overall doing better. The patient reported constant pain to his lower back on the left. refilled Anaprox DS, recommended discontinuing over-the-counter (OTC) naproxen and continuing gabapentin and Norco.

On May 26, 2013, the patient was evaluated for low back pain radiating to the bilateral legs. The pain level was 10/10. The quality of pain was described as piercing, sharp, shooting and throbbing. The patient was doubtful for cauda equina syndrome. He was treated with injection Dilaudid intramuscularly (IM).

On May 29, 2013, the patient was again evaluated for back pain. He was treated with IM injection of Dilaudid and prescribed Norco at the time of discharge.

On May 30, 2013 evaluated the patient for back pain. recommended undergoing a selective nerve root injection considering the patient's pain.

On May 30, 2013 performed a computerized tomography (CT) guided left L5 nerve root block.

On June 4, 2013 noted the patient had relief from the nerve root injection. The patient stated that he was walking better and he continued to take his gabapentin. He stated that he continued to have burning pain that went to the left leg. recommended continuing gabapentin and naproxen and starting gentle stretching exercises after ice and heat to the back.

On June 10, 2013 evaluated the patient for left lower back pain with radiculopathy down the left leg. The patient stated that since the injection he had about 34% relief of his back pain along with a decrease in radiculopathy as well. He said he was able to be more functional since that injection. His MRI of the lumbar spine showed that he had some impingement on the L5 nerve root on the left side. diagnosed lumbar intervertebral disc disease, lumbosacral radiculopathy, left sacroiliitis, lumbosacral spondylosis, lumbar intervertebral disc disease and lumbosacral radiculopathy and recommended an L4-L5 epidural steroid injection (ESI) with concentration to the left of midline. increased gabapentin to 600 mg t.i.d. Referral for a RS Medical to fit the patient for a back brace was given. The patient was also referred for physical therapy (PT).

On June 10, 2013 performed an interlaminar L4-L5 ESI to the left of midline.

On June 13, 2013 evaluated the patient for ongoing low back complaints. The patient stated that he believed he was at least 40% better but not quite to being 50% better. prescribed Naprosyn, ordered PT and referred the patient to the Clinic to determine if the patient was a surgical candidate.

From June 19, 2013, through August 5, 2013, the patient attended 13 sessions of PT consisting of therapeutic exercises and manual therapy.

On July 11, 2013 noted that the patient had made excellent progress. The patient had two more PT sessions left. He found them to be most helpful. recommended continuing gabapentin and naproxen and decreasing the Skelaxin use. The patient was to continue his PT. He would benefit from additional sessions.

On August 5, 2013, the patient stated that he had regressed just a little bit. He had increased his activity level and his back started hurting again. His employer was not able to accommodate his work restrictions. The patient stated that the left side of the back extending to his buttocks was what he described as some tingling to the lateral side of the leg that extended to the midfoot. Diagnosis was left central disc protrusion L4-L5 impinging on the traversing nerve root on the left and minimal disc bulge L5-S1 with associated central annular fissure. recommended completing PT and placed the patient on restricted duties.

On August 9, 2013, x-rays of the lumbar spine showed disc space narrowing at L4-L5 and L5-S1. Atherosclerotic calcifications were noted within the retroperitoneum.

On August 13, 2013, the patient stated that he had seen. They had recommended partial discectomy at the L4-L5 disc area. The patient was noted to have failed conservative treatment. He had PT and had a selective nerve root block (SNRB) and used gabapentin. He had made probably a 50% to 60% improvement over the first time when previously seen but he continued to have pain. Ms. recommended awaiting approval for the surgery. Once the surgery was complete and the patient had his orthopedic return appointment after the surgery, he could follow-up.

Per the utilization review dated August 20, 2013, the request L5-S1 discectomy was appropriate as an outpatient. However, the appropriate CPT codes would be 63030 and 69990 and not 63047. Approval was given for an L4-L5 discectomy with the use of the microscope. CPT codes were negotiated and 63047 was denied while 63030 and 69990 were approved. That procedure would be done as an outpatient.

On September 16, 2013, noted that the patient had been scheduled for surgery on September 23, 2013. The patient continued to have pain and was looking forward to getting the surgery done and seeing if that would help his pain level. encouraged the patient to stop smoking.

On September 19, 2013 evaluated the patient for back and left lower extremity pain. In contrast to the last visit, the patient stated he was having less radicular pain into the left lower extremity and less numbness. He stated that the mild symptoms he had in a radicular fashion down the left lower extremity he could "live with." He was much clearer that his pain was in the left side of his low back at the lumbosacral junction and in the left buttock region. diagnosed L4-L5 disc

herniation eccentric to the left with improved left lower extremity radicular complaints, although still having some mild radicular complaints, mild kyphosis at L4-L5 secondary to the disc herniation and spondylosis and trace anterolisthesis of L4 on L5 with forward flexion. had previously planned a left L4-L5 decompression for the disc herniation and radicular component of the patient's pain. However, with conservative care that had substantially improved. The patient would like to consider intervention that would also have the chance of addressing his low back pain. felt that the micro-decompression would not be reliable to treat the patient's back pain, especially given some mild kyphosis and trace anterolisthesis at that level. For that reason, he recommended an interbody fusion with instrumentation at L4-L5 to treat both his residual radicular complaints and his low back pain.

On September 19, 2013 performed a preoperative risk assessment due to history of tobacco abuse, complex sleep apnea, gastroesophageal reflux and hyperlipidemia prior to L4 discectomy and L4-L5 fusion. felt that there were no contraindications to the proposed surgery. He strongly encouraged the patient's smoking cessation efforts and hopefully he would be off of cigarettes for the time of surgery.

Per utilization review dated October 2, 2013, a left L4-L5 discectomy with decompression of the left L5 nerve root was appropriate. No fusion was indicated at that time.

On October 2, 2013 evaluated the patient for ongoing complaints. The patient stated that he was very frustrated in his Worker's Compensation paperwork and surgery paperwork was being handled. The patient continued to have pain. He stated that naproxen bothered his stomach. changed it to Mobic.

Per utilization review dated October 7, 2013, three day inpatient stay for lumbar L4-L5 laminectomy, posterior non segmental instrumentation, combined fusion, posterolateral fusion with posterolateral interbody fusion and posterolateral fusion was denied based on the following rationale: *"A male with low back pain and a left L5 radiculopathy secondary to a left L4-L5 herniated nucleus pulposus (HNP) with nerve compression and no significant instability by x-rays reported when I previously approved a left L4-L5 discectomy only on August 21, 2013. The patient persists with symptoms, but does have some more back pain. He also has degenerative disc disease (DDD) at L5-S1 in the absence of a herniation. No new objective findings are documented on the most recent doctor encounter on September 19, 2013. Based on this clinical picture and official disability treatment guidelines, the requested procedure was denied. A left L4-L5 discectomy with decompression of the left L5 nerve root was appropriate. No fusion was indicated."*

Per reconsideration review dated October 16, 2013, the appeal for inpatient x3 lumbar laminectomy, posterior non segmental instrumentation, combined fusion, posterolateral fusion with posterolateral interbody fusion L4-L5 and posterolateral fusion was denied based on the following rationale: *"The previous non-*

*certification on October 4, 2013, stated that the L4-L5 discectomy with decompression of the L5 nerve root would be appropriate, but the fusion was not supported by the guidelines without documentation of instability. There are no additional medical records available for review. The previous non-certification is supported. The guidelines do not support lumbar fusion without documentation of instability. There is no diagnostic imaging documenting any nerve root instability. The claimant has no neurological deficits on physical examination. The guidelines require a psychosocial evaluation with confounding issues address and there is no documentation supporting this. Based upon the medical documentation provided for review and the peer-reviewed, evidence-based guidelines, the request is not medically supported. The appeal request for inpatient x3, lumbar laminectomy, posterior non segmental instrumentation, combined fusion, posterolateral fusion with posterolateral interbody fusion at L4-L5, posterolateral fusion is not certified."*

On October 23, 2013, Ms. evaluated the patient for ongoing back complaints. The patient stated that his surgery was scheduled for November 5, 2013. He stated that he continued to have pretty intense back pain which was not getting better. The leg pain had gotten somewhat better. He was getting quite frustrated and ready to proceed with his surgery. stopped Skelaxin and Flexeril. The patient was requesting a different muscle relaxer.

On November 19, 2013 performed a peer review and rendered the following opinions: (1) When noting the reported mechanism of injury, tempered by the current findings after the physical therapy it was clear that there was still a residual diagnosis of a disc herniation at L4-L5. There was nerve root compromise noted as well. It could not be said that there was ongoing radiculopathy based on the lack of specific symptomatology but the nerve root compromise was still an issue. (2) When noting the marginal findings, it could be opined that the lumbar spondylosis, kyphosis and trace anterolisthesis were not a function of the reported mechanism of injury of twisting while in a seated position. That compensable event resulted in the noted disc lesion and nerve root compromise alone. The other findings were coincidental ordinary disease of life degenerative changes and related to the reported mechanism of injury. (3) Given the marked improvement with conservative care the patient would be suggested a home exercise protocol emphasizing overall fitness conditioning and achieving an ideal body weight. Furthermore, noting that there was a significant disc herniation, smoking cessation would also be strongly encouraged. Until there was an increase in symptomatology there was little else to do. Occasional use of over-the-counter (OTC) analgesic preparations would be supported.

On December 9, 2013 gave a prospective IRO review response. felt that the three day inpatient lumbar laminectomy, posterior non-segmental instrumentation, combined fusion, posterolateral fusion with posterolateral interbody fusion at L4-L5 as requested in a patient with no evidence of significant segmental instability and lack of performance of presurgical screening as related to confounding variables that they might affect the overall success of the suggested surgical

procedure was not supported and was not medically reasonable or necessary at that time.

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

Rationale: This patient with a 60-pack-year smoking history on xx/xx/xx, pivoted with subsequent note of low back pain.

The patient initially sought care with his chiropractor who then also provided chiropractic adjustment and then acupuncture treatment. The patient did not get benefit and the patient was then seen by his primary care physician. The patient was noted to have hematuria. The patient was not able to continue with the primary care physician due to the work injury basis of this claim and sought care. His Initial evaluation was with nurse practitioner on May 7, 2013, who outlined the patient's previous care noting the patient on exam, had a positive straight leg raise on the right with normal reflexes and normal sensation. The patient was provided prescriptions of Norco, Skelaxin and tramadol plus home therapy was recommended. An MRI of the low back was also ordered and the patient was placed off work.

On May 10, 2013, the MRI of the lumbar spine showed an L4-L5 central and left disc protrusion with impingement of the traversing L5 nerve root on the left with minimal disc bulge at L5-S1 with an associated central annular fissure at L5-S1. There was no report of nerve root pressure to the right side at L4-L5.

On May 14, 2013 reviewed the MRI report. He noted that the patient was complaining of intermittent radiation of pain into the left lower extremity into the thigh and calf where there was numbness. The patient ambulated with a forward flexed posture and was utilizing a cane.

proposed discontinuation of Skelaxin but to continue the Norco and naproxen and he proposed the selective nerve root block with interventional radiology.

The patient was seen on two occasions May 26, and May 29, 2013. He initially reported to the nurse that he was having suicidal ideations but that was not confirmed with the physician evaluation but that the patient was trying to point out the severity of his symptoms. The patient was given Dilaudid injection each visit.

On May 30, 2013 performed the CT-guided left L5 nerve root injection with approximately 30-40% improvement noted by nurse practitioner. However, the patient still had significant residual straight leg raise abnormality subjectively and the patient was walking with two canes.

The patient had an interlaminar L4-L5 injection performed on June 10, 2013. On June 13, 2013, nurse practitioner noted the patient was approximately 40% better. However, the patient did report one episode of incontinence but no further

intervention was proposed except for referral. He was now ambulatory with one cane.

The patient then had approximately 13 sessions of therapy from June 19, 2013, through August 5, 2013.

On August 5, 2013, the patient was reassessed and noted to have per the report to nurse practitioner some regression of his improvement although only mildly. The patient was recommended to complete therapy.

On August 9, 2013, flexion-extension x-rays were performed of the lumbar spine. These were interpreted to show no significant abnormal translation on flexion and extension. There were atherosclerotic calcifications within the retroperitoneum. There was also disc space height loss at L4-L5 and L5-S1.

The patient was assessed apparently before August 13, 2013, although that initial report is not available. had proposed L4-L5 partial discectomy. This was approved by utilization review on August 20, 2013. However, the patient was reassessed and noted to have improvement in his neurological dysfunction but that the low back discomfort was still ongoing. felt that the microdiscectomy would not be able to treat the patient's low back pain and now proposed an interbody fusion procedure.

The patient was seen for a preoperative medical evaluation who recorded the significant 60-pack-year smoking history as well as complex sleep apnea, reflux and hyperlipidemia. He felt that there were no contraindications to the proposed surgery but proposed the patient should be weaned off of cigarettes. performed another preauthorization utilization review on October 2, 2013, for the proposed decompression and fusion procedure. did not concur with the proposed fusion procedure.

The patient then had reconsideration apparently done. This reconsideration request was denied for medical necessity for the fusion procedure at L4-L5.

On November 19, 2013 performed a peer review noting that the patient had degenerative changes of the lumbar spine. The MRI findings of the disc lesion and nerve root compromise would be the compensable event.

There was also a prospective IRO review response on December 9, 2013, noting that the patient had no evidence of segmental instability and that there had been no presurgical screening for the assessment of confounding variables.

Summary: This patient has a disc protrusion at L4-L5 with apparent L5 nerve root abutment possible compression with symptoms that have far out shadowed the pathology represented on the MRI. The patient is also a chronic smoker. He has also pain issues that are not well evaluated by the treatment team. The proposed surgery at L4-L5 would not address the issues of the degenerative and narrow

disc at L5-S1 but with the fusion of L4-L5, there would be increased stress placed on L5-S1.

The patient does not have any instability documented on the flexion-extension views. Thus, the patient does not meet ODG criteria for this proposed fusion procedure at L4-L5. There appears to be also significant psychosocial issues that have not been addressed to date.

Thus, the request for the services in dispute namely the laminectomy and instrumentation and fusion at L4-L5 are not approved as a medical necessity and the adverse determinations previously provided 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**