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Notice of Independent Review Decision

August 5, 2015

Amended: August 12, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient one-day stay with L4-L5 posterior lumbar interbody fusion.

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx when picking up two cases of towels. He was diagnosed with sprain/strain of the lumbar spine and other joint derangement not otherwise specified.

2013: On September 5, 2013, x-rays of the lumbar spine revealed minimal endplate changes of degenerative disc disease best evident at L4-L5. There was moderate multilevel facet hypertrophy due to degenerative facet arthritis, best evidence at L3-L4 or L4-L5 and L5-S1. The indication was

low back pain.

On October 11, 2013, magnetic resonance imaging (MRI) of the lumbar spine revealed at L5-S1, there was posterior disc herniation measuring approximately 1 mm with facet joint changes causing mild indentation on the thecal sac. *The report is incomplete.*

2014: On June 11, 2014, evaluated the patient for lumbar sprain/strain injury. The patient complained of lower back radiating bilaterally to leg right greater than left with numbness to right lower extremity. He rated the pain at 8-9/10. He was utilizing tramadol, naproxen and baclofen for pain with little improvement. It was noted that he had completed 12 sessions of aquatic therapy with some improvement. MRI of the lumbar spine was reviewed that showed degenerative disc with extrusion to the left side at L4-L5. diagnosed sprain of unspecified site of back and recommended EMG/NCS of the lower extremities to consider epidural steroid injection (ESI) at L4-L5.

On July 29, 2014, EMG/NCS of the lower extremities revealed electrodiagnostic evidence of a mild, active, right L5 radiculopathy. *The report is illegible.*

2015: On January 1, 2015, evaluated the patient for chief complaint of lower back pain radiating down the right lower extremity. diagnosed lumbar/thoracic radiculopathy and lumbar disc herniation. The patient was recommended MRI of the lumbar spine. The patient was also recommended right L4-S1 transforaminal ESI to improve pain and functionality. Medications were continued unchanged.

On January 26, 2015, MRI of the lumbar spine revealed degenerative disc disease and facet arthropathy; L4-L5 moderate bilateral facet arthropathy, mild degenerative disc disease, grade I degenerative spondylolisthesis and mild right neuroforaminal stenosis; and L5-S1 mild right-sided and moderate left-sided facet arthropathy.

On February 2, 2015, noted the patient continued with low back pain and right lower extremity pain disrupting his daily activities. reviewed the lumbar MRI and submitted approval for right L4-S1 transforaminal ESI. He was to consider surgical evaluation.

On February 16, 2015, noted the patient continued with pain. reviewed the MRI of the lumbar spine and diagnosed thoracic/lumbosacral neuritis or radiculitis. The patient was recommended right micro-foraminotomy at L4-L5 at Cornerstone. The patient elected to proceed.

On March 26, 2015, performed a psychological evaluation on the patient and diagnosed pain disorder associated with both psychological factors and chronic general medical condition, chronic adjustment disorder with depression and anxiety and sleep disorder due to a chronic medical condition. recommended individual counseling.

On May 11, 2015, noted the patient complained of back and right leg pain and numbness. The patient was ambulating with the help of a cane. There was some difficulty standing or sitting. The

patient was utilizing tramadol, naproxen and baclofen. On examination, the lumbar spine showed forward flexion of 60 degrees, hyperextension of 25 degrees, lateral bending of 25 degrees bilaterally, and motor strength abnormal in heel walking bilaterally. The sensory examination was decreased in the L4-L5 distribution bilaterally. Knee jerks were absent bilaterally and ankle jerks were normal. Straight leg raise testing was positive bilaterally. It was noted that the patient had completed twelve sessions of physical therapy without improvement and an epidural steroid injection also provided no improvement. recommended PLIF L4-L5.

Per utilization review dated May 28, 2015, the request for inpatient one-day stay with L4-L5 posterior lumbar interbody fusion was denied with the following rationale: *“All pain generators should be identified and treated. All physical medicine and manual therapies should have been completed and x-rays should demonstrate spinal instability. Imaging should demonstrate disc pathology correlating with symptoms and physical examination findings. A psychosocial screen should have been performed. There must be documentation of refraining from smoking for at least six weeks prior to surgery and during the period of fusion healing. The patient is a tobacco user with no documentation of refraining from smoking for at least six weeks prior to surgery. There were no x-rays demonstrating spinal instability with flexion/extension views. The request for an L4-L5 posterior lumbar interbody fusion with one day inpatient length of stay is not certified.”*

On June 16, 2015, x-rays of the lumbar spine revealed degenerative disc disease and facet joint disease at L4-L5 and mild 3 mm spondylolisthesis of L4 during flexion only, likely degenerative.

On June 23, 2015, performed a designated doctor evaluation (DDE) and certified that the patient had not reached maximum medical improvement (MMI), but was expected to reach on or about March 16, 2016.

Per reconsideration review dated June 29, 2015, the appeal for inpatient one-day stay with L4-L5 posterior lumbar interbody fusion was denied with the following rationale: *“Based on the clinical data provided, objective data suggests a L5 radiculopathy. The plain x-ray findings would suggest foreshortening of the L4 foramina with an anterolisthesis a L4-L5. The question is whether the L5-S1 level contributes to the L5 radiculopathy. The requested services are denied again. Consideration might be given to imaging in the form of CT myelography to assess both nerve compression and instability at both the L4-L5 and L5-S1 levels.”*

Per reconsideration review dated July 14, 2015, the appeal for inpatient one-day stay with L4-L5 posterior lumbar interbody fusion was denied with the following rationale: *“The physical examination findings and diagnostic imaging have not provided significant evidence of instability. The Guidelines would not support lumbar spinal fusion without clear evidence of instability or significant segmental motion of greater than 4.5 mm, which has not been documented. The request for inpatient times one with lumbar L4-L5 posterior lumbar interbody fusion is not certified.”*

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

Rationale: This patient had a work injury reported on xx/xx/xx, when he was picking up boxes weighing approximately 35 to 40 pounds per the office records. He was diagnosed subsequently with a lumbar spine sprain/strain.

The patient did have x-rays obtained in September 2013, which showed endplate changes and degenerative disc disease most evident at L4-L5 with multilevel facet hypertrophy also seen at L3-L4, L4-L5, and L5-S1.

There was reference to an MRI of October 11, 2013, the report is incomplete. This showed posterior disc abnormality at L5-S1 measuring approximately 1 mm.

The patient was then evaluated on June 11, 2014, for a lumbar sprain/strain. He noted the patient had symptoms in to both lower extremities right greater than left with numbness to the right lower extremity (*Reviewer's comment: No dermatomal distribution reported*). Pain level was 8 to 9 on a 10 scale. The patient did report increased symptoms with standing or sitting. The patient was utilizing medications of tramadol, naproxen and baclofen with little improvement.

The patient had completed 12 therapy sessions with mild improvement. noted the MRI of the lumbar spine showed degenerative disc with "extrusion" (*Reviewer's comment: Likely extrusion*) to the left side at L4-L5. diagnosed a sprain of the lumbar spine and recommended an EMG/nerve conduction and consideration of epidural steroid injections. Please note that does document that the patient is an every day smoker.

On July 29, 2014, interpreted the EMG/nerve conduction study of the lower extremity. obviously did not do any physical exam to correlate with the interpretation. There was suggestion that there was some mild active right L5 radiculopathy. However, the report is somewhat illegible.

On January 1, 2015, evaluated. He noted that the patient had pain symptoms into the right lower extremity with also low back pain. proposed an L4 to S1 transforaminal ESI. A MRI was also ordered.

On January 26, 2015, the lumbar MRI showed degenerative disc disease and facet arthropathy at L4-L5 with mild right neural foraminal narrowing at L4-L5 on the right but the left neural foramen was considered patent. The L5-S1 foramens were also considered patent although there was degenerative disc disease noted and also facet arthropathy. The patient was noted at L4-L5 to have a grade I degenerative spondylolisthesis. There was no documentation of any disc protrusion or herniation at the L4-L5 or L5-S1 level.

on February 2, 2015, reviewed the lumbar MRI and requested approval for the right L4-S1 transforaminal ESI.

on February 16, 2015, noted that the patient had had an ESI on February 11, 2015, with only two

days relief. reviewed the MRI and diagnosed thoracic and lumbosacral neuritis or radiculitis. Please note on exam, now reported that the anterior tibialis only had 3/5 strength and the gastroc 4/5 strength on the right side but the EHL was 5/5 bilaterally. (This would make little physiological sense given the MRI findings).

On March 26, 2015, a psychological assessment was performed on Mr. noting he had psychological factors and general medical conditions consistent with a chronic adjustment disorder with depression and anxiety and individual counseling was proposed.

On May 11, 2015, the patient was reassessed noting that the patient on lumbar spine exam showed decreased motor strength ability and heel and toe walking bilaterally; however, on clinical exam, the patient now is reported to have ankle dorsiflexion strength at 5/5 bilaterally. (*Reviewer's comment: Obviously significant inconsistency between the evaluation dates*). The straight leg raise was reported to be positive bilaterally. noted that the epidural had not provided any significant benefit and now he recommended a posterior lumbar interbody fusion at L4-L5.

There were two utilization reviews performed. both denied the medical necessity for the proposed L4-L5 posterior lumbar interbody fusion with one day inpatient stay.

On June 16, 2015, lumbar spine radiographs with flexion extension were completed showing 3 mm spondylolisthesis of L4 during flexion only and this was considered degenerative.

performed a designated doctor examination on June 23, 2015. He proposed that the patient was not maximum medical improvement. He also stated that the ODG criteria would not apply secondary to delay in care. He expected that the patient would be at maximum medical improvement approximately March 16, 2016.

The records end at this point.

Summary: This patient in his early xx's has a degenerative spondylolisthesis of L4-L5 without verifiable neurological deficits. There is no instability even on flexion extension radiographs. In addition, the patient is a smoker. The patient has no disc protrusion or herniation as associated with the work incident. The findings on his lumbar spine MRI are all degenerative.

Thus, the patient does not meet ODG criteria independent of causation issues for a spine fusion operation as he has no progressive neurological deficit or instability and obviously there is no fracture. He also has contraindications to proceeding with such as he is a smoker which inhibits bone fusion incorporation.

Thus, the proposed posterior lumbar interbody fusion adverse determination is upheld by this IRO reviewer.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES