

MATUTECH, INC.

DATE OF REVIEW: APRIL 6, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Discectomy at L4-L5 and L5-S1.

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

The physician providing this review is a spinal neurosurgeon. The reviewer is national board certified in neurological surgery. The reviewer is a member of the American Association of Neurological Surgeons, The Congress of Neurological Surgeons, The Texas Medical Association, and The American Medical Association. The reviewer has been in active practice for 38 years.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office notes (09/29/06 – 03/19/07)
- Radiodiagnostics (10/16/06)

M.D.:

- Office notes (11/03/06 – 03/12/07)
- Radiodiagnostics (10/16/06 – 02/13/07)
- Utilization reviews (03/07/07 & 03/15/07)

M.D.:

Office visits cum procedure notes (11/03/06 – 02/26/07)

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a patient who was injured while working on a derrick. He tripped on some beams and twisted his back while falling injuring his lower back.

After the injury, M.D., evaluated the patient for back pain with stiffness in the right hip and pain shooting down the back of the upper thigh and leg. The patient had

a lumbar surgery in 1998 and had not had any back problems till his current injury. X-rays of the lumbar spine was within normal limits. Dr. diagnosed back strain and right-sided sciatica; started the patient on cyclobenzaprine, tramadol, Skelaxin, trazodone for insomnia; and recommended physical therapy (PT).

Magnetic resonance imaging (MRI) of the lumbar spine in October showed: (a) degenerative disc disease (DDD) with prior lumbar surgery; (b) height loss at L3-L4; (c) broad-based disc bulge at L4-L5 with mild canal effacement and neural foraminal narrowing; (d) right-sided disc bulge at L5-S1 with right neural foraminal impingement. Dr. added the diagnosis of the lumbar radiculopathy and started the patient on hydrocodone/APAP in addition to the ongoing medication. From November through December, M.D., performed a series of three epidural steroid injections (ESIs) at L5-S1 on the right and prescribed Neurontin.

In January 2007, Dr. noted the ESI had not provided any relief. Lumbar myelogram showed mild compression of the right dorsal lateral margin of the thecal sac at L5-S1 possibly contacting the shoulder of the passing right S1 nerve root and ventral indentation of the thecal sac from L3-L4 through L5-S1. Post-myelogram computerized tomography (CT) showed degenerative annular disc bulge at L4-L5 and L5-S1 with associated endplate spondylosis. The patient was evaluated by M.D., in March stating that he did not wish to continue conservative care. Dr. discussed decompression with foraminotomies, discectomies, and osteophylectomies especially at L5 and S1.

On March 7, 2007, foraminotomies at L4-L5 and L5-S1 on the right was denied stating the following rationale: *The patient was noted to be neurologically intact except for a trace weakness of the extensor brevis on the right. The patient was noted to have had prior foraminotomies as well as three ESIs from a posterior approach without benefit. There had been no evidence of any radiculopathy, and no selective nerve root block (SNRB) to further localize a pain generator.* Dr. appealed the denial on March 15, 2007, which was once again denied stating the following rationale: *While there was evidence in favor of discectomy for prolonged symptoms of lumbar disc herniation in patients with a shorter period of symptoms but no absolute indication for surgery, there were only modest short-term benefits, although discectomy seemed to be associated with a more rapid initial recovery, and discectomy was superior to conservative treatment when the herniation was at L4-L5.*

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

MEDICAL MATERIAL REVIEWED LISTED NUMERICALLY INCLUDED:

1. A CLINICAL HISTORY SUMMARY BY MATUTECH INCORPORATED
2. 9/29/06 NOTE BY M.D. AND NOTES BY THE SAME DOCTOR ON 10/4/06, 10/25/06, 11/21/06, 3/19/07
3. 10/16/06 LUMBAR MRI REPORT BY

4. NEW PATIENT EVALUATION ON 11/3/06 BY M.D. ALONG WITH EPIDURAL STEROID INJECTION REPORTS BY THE SAME DOCTOR ON 11/27/06 AND 12/18/06
5. M.D. 2/5/07, 3/1/07, 3/12/07
6. LUMBAR CT MYELOGRAM REPORT 2/13/07 BY M.D.

THIS CASE INVOLVES A MALE WHO TWISTED HIS BACK ON A DRILLING RIG WHEN HIS FOOT CAUGHT AND HE FELL ON. THE PAIN WAS MINOR INITIALLY BUT THE NEXT DAY IT DEVELOPED NOT ONLY IN HIS BACK BUT INTO HIS RIGHT LOWER EXTREMITY ESPECIALLY INTO HIS RIGHT HIP. THERE WAS A HISTORY OF 1998 LUMBAR SPINE SURGERY FROM WHICH HE RECOVERED APPARENTLY WELL ENOUGH TO RETURN TO RATHER STRENUOUS ACTIVITY AT WORK. PAIN PERSISTED DESPITE PHYSICAL THERAPY AND MEDICATIONS AND ON 10/16/06 A LUMBAR MRI WAS DONE SHOWING CHRONIC CHANGES AT L4-5 WITH SOME QUESTION OF L5-S1 DISC TROUBLE CAUSING RIGHT SIDED NERVE ROOT COMPRESSION. MORE PHYSICAL THERAPY AND MEDICATIONS WERE NOT SUCCESSFUL AND EPIDURAL STEROID INJECTIONS WERE PERFORMED ON THREE OCCASIONS IN NOVEMBER AND DECEMBER OF 2006 WITHOUT SIGNIFICANT HELP. THE PATIENT'S EXAMINATION HAS CONSISTENTLY SHOWED POSITIVE STRAIGHT LEG RAISE AND SOME WEAKNESS OF DORSIFLEXION OF THE RIGHT GREAT TOE.

I DISAGREE WITH DENIAL FOR THE PROPOSED OPERATIVE PROCEDURE. BOTH THE L4-5 AND L5-S1 LEVELS ARE POTENTIAL SOURCES OF HIS DIFFICULTY WITH POTENTIALLY CORRECTABLE PATHOLOGY ON BOTH MRI AND CT MYELOGRAM. DIFFERENT SURGEONS MAY APPROACH THE PROBLEM DIFFERENTLY AND SOME WOULD INCLUDE FUSION IN THE PROCESS BUT I THINK THE PROPOSED OPERATIVE PROCEDURE OF DECOMPRESSION WITH PROBABLE DISCECTOMY AT THE L4-5 AND L5-S1 LEVELS STANDS A REASONABLE CHANCE OF HELPING THIS PATIENT GET BACK TO A MORE ACTIVE LIFE STYLE. ANOTHER FACTOR IN MY OPINION IS THAT HE HAS PERSISTED WITH SIGNIFICANT SYMPTOMS DESPITE ADEQUATE CONSERVATIVE ATTEMPTS AT DEALING WITH HIS TROUBLE AND HAS BEEN INCAPACITATED FOR THE PAST SEVEN MONTHS.

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

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

“Guidelines developed by the reviewer over 38 years of evaluating spinal surgical problems.”