

# **MATUTECH, INC.**

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**AMENDED  
01/09/08**

**DATE OF REVIEW: DECEMBER 31, 2007**

**IRO CASE #:**

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

Right L3-L4 hemilaminectomy, foraminotomy, and discectomy (63030)

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

Board Certified Orthopaedic Surgeon

**REVIEW OUTCOME**

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

X Overturned            (Disagree)

Medical documentation supports the medical necessity of the Right L3-L4 hemilaminectomy, foraminotomy, and discectomy (63030)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Texas Department of Insurance

Office notes (07/14/05 – 09/18/07)

Procedures (08/17/05 – 10/26/05)

Diagnostics (11/02/05 – 01/26/07)

Utilization review (11/26/07)

Designated doctor examination/RME (02/13/07 – 11/06/07)

M.D.

Office visits (11/02/05 – 09/18/07)

Diagnostics (11/02/05 – 01/26/07)

Procedures (08/17/05 – 10/26/05)

Designated doctor examination/RME (02/13/07 – 09/11/07)

**The denials are based on Official Disability Guidelines and AMA Guides 5<sup>th</sup> edition page 382-383. Copies were not submitted by the insurance company.**

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

The patient is a male who was moving some freezers, when he felt pain in his back. Over the course of next day, the pain started radiating around the right groin and anterior thigh. After the injury, he continued to work without restrictions for two weeks.

**PRE-INJURY RECORDS:** In July 2005, M.D., saw the patient for left leg radiculopathy and left toe numbness. Magnetic resonance imaging (MRI) of the lumbar spine was consistent with nerve root impingement. Dr. assessed lumbago and left L4/L5 radiculopathy, and performed a caudal epidural steroid injection (ESI) and a selective nerve root block at L4-L5.

**POST-INJURY RECORDS:** Following the injury, Dr. noted re-development of the severe low back pain and left leg radiculopathy. He repeated a caudal ESI and selective nerve root block at L4-L5. M.D., an orthopedic surgeon, evaluated the patient for right groin and anterior thigh pain. He noted the patient had been treated with lumbar laminectomy in the past for the left lower extremity radiculopathy. The recent caudal ESI had resolved his left-sided symptoms, but his right-sided symptoms had persisted. X-rays of the lumbar spine revealed traction osteophytes anteriorly at L1-L2, L2-L3, and L3-L4. MRI of the lumbar spine revealed: (1) a right-sided lateral and foraminal protruding disc at L3-L4 with a superior prolapse component lying behind the L3 vertebra causing asymmetric marked foraminal stenosis on the right. (2) Disc desiccation and degenerative spondylosis involving L2-L3 and L3-L4 greater than the remaining levels. (3) Status post remote left L5-S1 laminectomy. (4) Mild hypertrophic facet arthropathy bilaterally at L4-L5.

In January 2006, electromyography/nerve conduction velocity (EMG/NCV) study revealed acute and chronic right L4 radiculopathy. The patient underwent two transforaminal ESIs with much relief. Dr. felt the patient could return to work without restrictions. However, in April 2006, the patient had return of symptoms and he underwent another set of two lumbar ESIs at the right L3-L4.

A repeat MRI of the lumbar spine revealed: (1) Minimal 1-mm bulges from L2-L3 through L4-L5. (2) A bulge at L3-L4 with a superimposed 3-mm right foraminal protrusion causing moderate stenosis of the right L3-L4 foramina. (3) Mild stenosis in the right L2-L3 and bilateral L4-L5 foramen. (4) A 2-mm central protrusion at T11-T12 indenting the thecal sac. (5) Left hemilaminectomies at L4-L5 and L5-S1. A small amount of enhancing granulation tissue in the left lateral epidural space at L5-S1.

In 2007, a lumbar myelogram/computerized tomography (CT) revealed: (1) Mild degree left convexity (estimated at 10-12 degrees) scoliosis. (2) Isolated and advanced degree degenerative disc disease (DDD) at L2-L3 with narrowed discal width by 75-85% with interspace vacuum phenomenon, endplate sclerosis, and anterior and left lateral marginal osteophytes. (3) A moderate degree DDD at

L3-L4 with narrowed discal width by 50% with endplate sclerosis and spondylosis.

In February 2007, M.D., performed a post designated doctor (DD) required medical examination (RME). He noted the following treatment history: *The patient had had prior laminectomy/discectomy at L4-L5 and L5-S1 in December 2001. Later, he was certified with 10% whole person impairment (WPI) rating. Following the injury, he was treated with medications and lumbar ESIs. In an RME of January 6, 2006, M.D., opined as follows: The patient had acute right L3-L4 foraminal disc herniation and sprain/strain of the back. The ongoing treatment was reasonable. A selective nerve root block at L3-L4 and physical therapy (PT) would be appropriate and ultimately would need discectomy. On April 13, 2006, D.O., a DD, did not place the patient at MMI. In a post-DD RME dated May 30, 2006, Dr. did not place him at MMI and opined he might benefit from a surgical procedure. In another examination on July 11, 2006, Dr. stated the injury resulted in right L3-L4 stenosis which was opposite to the previous left-sided laminectomy performed. Thus this was a new injury on a new level and on a different side. In August and September 2006, the right L4 nerve root blocks were performed x2 with minimal effect and eventually D.O., requested decompression surgery which was denied in October 2006, because the patient was obese. On November 30, 2006, Dr. did not place him at MMI. In December 2006, the patient was allowed to return to work with restrictions. Dr. rendered the following opinions: (1) The patient responded to ESIs and the old herniated disc had retracted. Physical examination did not correlate with an L4 radiculopathy, but what appeared to be a lateral femoral cutaneous nerve abnormality. (2) He was at MMI with 8% WPI rating. No active treatments were likely to help him.*

In April 2007, Dr. noted significant and persistent radicular complaints. He recommended right L3-L4 hemilaminectomy, foraminotomy, and discectomy. (The patient weighted 310 pounds).

In September 2007, Dr. placed him at MMI with 5% WPI rating. He felt the patient was not a surgical candidate. On examination, he noted loss of the left Achilles reflex which was actually due to the previous surgery. Dr. felt the patient was a surgical candidate and refilled medications.

M.D., assessed statutory MMI as of November 2, 2007, and assigned 5% WPI rating.

On November 26, 2007, the requested lumbar surgery was denied with the following rationale: *The patient is reportedly 70 inches tall weighing 315 pounds. It is unclear if the patient has had any weight reduction. Prior to surgical intervention, the patient should reduce his body mass index. The patient's body habitus places him at risk to re-herniation. Surgery may be warranted in the future depending on his significant weight loss.*

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

THE DENIAL OF AN INDICATED SURGICAL PROCEDURE BASED SIMPLY ON PATIENT WEIGHT AND INABILITY TO LOSE WEIGHT IS NOT IN THE BEST INTEREST OF THE PATIENT. IN ADDITION, IT IS UNETHICAL TO WITHHOLD TREATMENT BASED ONLY ON A PATIENT'S WEIGHT WHEN THE SURGICAL INTERVENTION PROPOSED IS CLEARLY INDICATED. MR. ONEIL HAS A DOCUMENTED HERNIATED DISC WITH RADICULOPATHY AND HAS FAILED CONSERVATIVE TREATMENT. IT IS OFTEN DIFFICULT TO PERFORM ENOUGH ACTIVITY TO LOSE SIGNIFICANT WEIGHT DUE TO THE PAIN WHICH OCCURS WITH THIS CONDITION. WHILE AT MORE RISK FOR RE-HERNIATION, THE PROPOSED SURGICAL INTERVENTION IS CLEARLY INDICATED AT THIS TIME.

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

CLINICAL EXPERIENCE AS A BOARD CERTIFIED ORTHOPAEDIC SURGEON WAS UTILIZED DURING THIS REVIEW. IN ADDITION, STANDARD ORTHOPAEDIC SPINE SURGERY TEXTBOOKS WERE CONSULTED PRIOR TO ARRIVING AT THIS DECISION.

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

ODG must be used as a guide for the treatment of various Orthopaedic conditions. While obesity is clearly a risk factor for adverse outcomes in a variety of conservative or surgical treatments, it is never an absolute contraindication treatment. Excess weight is often difficult to lose due to multiple factors. One of these factors is the inability to perform adequate exercise based on pain or disability. Similarly, gender is often a risk factor for certain injuries (e.g. ACL tear.) However, one would never consider asking an individual to alter their gender or deny treatment based on such. Mr. clearly has failed conservative treatment and has all indications for the proposed surgical procedure. Therefore, his weight should not be used as an absolute contraindication for treatment.