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Notice of Independent Review Decision

DATE OF REVIEW: July 14, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Microdiscectomy of L2-L3 disc (63030)

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

Diplomate, American Board of Neurological Surgery

REVIEW OUTCOME

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

Overturned (Disagree)

Medical documentation supports the medical necessity of Microdiscectomy of L2-L3 disc (63030)

ODG criteria have been utilized for denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old who was injured on xx/xx/xx. He was lowering a case of orange juice and felt sharp pain and tightness in his low back.

In an initial evaluation, D.O., noted the following treatment history: *The patient had a significant history of multiple back surgeries and fusion from L4 through S1 due to a prior injury of xx/xx, when he fell off of a press and hit his back resulting in fractures and injuries to the discs. He was under the care of a chronic pain doctor and was taking methadone and hydrocodone. He had permanent work limitations and was not supposed to lift more than 10-20 pounds. However, at the current employment, he was lifting 50-60 lbs routinely. He had told the employer about this, but they did not move him out of the dairy department. The patient was also suffering from depression. X-rays of the lumbar spine revealed fusion at L4-L5 and L5-S1 with posterior instrumentation. There were arthritic and degenerative changes and disc narrowing consistent with chronic process. Dr. assessed lumbar sprain/strain status post fusion in 1987, 1988, and 1989; prescribed meloxicam, Robaxin, and Flexeril; and stated the patient could not return to pre-injury work.*

The patient attended few sessions of physical therapy (PT) consisting of

therapeutic exercises. Computerized tomography (CT) of the lumbar spine revealed: (1) Diffuse disc bulge with posterior facet and ligamentous hypertrophy appearing to cause moderate-to-severe lumbar stenosis at L3-L4 with bilateral neural foraminal narrowing. (2) Disc bulge and broad left disc protrusion at L2-L3 causing encroachment of the left lateral recess and proximal left neural foramen. (3) Disc protrusion on the right at T12-L1 mildly indenting the right anterolateral aspect of the thecal sac.

M.D., an orthopedic surgeon, noted the following history: *The patient initially injured his low back in xxxx requiring two surgical procedures. He did not return to work for two years following this. He had a second work-related low back injury in xxxx requiring a third surgical procedure. He did not return to work until year xxxx when he sustained a third work-related lower back injury. Electromyography/nerve conduction velocity (EMG/NCV) study revealed acute left L5 radiculopathy. Myelogram/CT scan of the lumbar spine revealed: (1) Asymmetric right paracentral disc protrusion at T12-L1. Slight encroachment upon the descending right L1 nerve. (2) Degenerative disc disease (DDD), disc bulge, and spondylosis at L2-L3 and L3-L4 with moderate central canal and lateral recess narrowing at L3-L4 as well as at L2-L3, asymmetric to the left at L2-L3 due to left paracentral disc extrusion deforming the left L3 nerve. (This was likely the cause of patient's symptoms). (3) Postoperative changes of fusion at L4-L5 and L5-S1.*

The patient underwent a lumbar ESI without significant relief.

M.A., L.P.C., saw the patient for symptoms of depression. The patient admitted to receiving counseling and psychotherapy services prior to the work injury. He indicated three previous suicide attempts and ideation secondary to his pain and loss from prior back injury between 1987 through 1992. Beck Anxiety Inventory (BAI) score was 21 reflecting moderate anxiety and Beck Depression Inventory (BDI)-II score was 36 indicating severe depression. The current GAF was 49 against the past year GAF of 80. Ms. assessed severe major depressive disorder and pain disorder. Ms. recommended six sessions of individual psychotherapy.

On May 15, 2008, D.O., denied the request for microdiscectomy at L2-L3 with the following rationale: *There was no pain relief with ESI at L2-L3. CT myelogram and EMG/NCV are not concordant for L2-L3 radiculopathy. Available diagnostic exam is without evidence of radiculopathy. Status post numerous lumbar injections. Must have conclusive concordant evidence before surgery.*

An EMG/NCV study showed severe and chronic left L5 radiculopathy and mild and chronic right L5 and left L4 radiculopathy. The patient attended five sessions of individual psychotherapy. A repeat EMG/NCV study revealed left L3 and L5 radiculopathies with more acute findings at the L3 level with ongoing denervation versus more chronic apparent changes at L5 level. Based on this, Dr. requested approval for decompressive surgery.

On June 4, 2008, M.D., a neurosurgeon, noted history of craniotomy for comminuted depressed skull fracture and placement of a spinal cord stimulator (SCS) for a previous history of occipital neuralgia. He diagnosed failed back syndrome, lumbar postlaminectomy syndrome, lumbar radiculitis, and lumbago. He stated that the patient was not a surgical candidate due to history of multiple

lumbar surgical interventions and current symptomatology inconsistent with myelographic findings. However, he would benefit from evaluation for insertion of an SCS.

On June 6, 2008, M.D., denied the appeal for L2-L3 microdiscectomy. Rationale: *Looking at this case chronologically, the three electrodiagnostic studies performed over time all have different conclusions. Dr. initially feels that the patient's problem is absolutely at the L3-L4 level, but then he changes his mind and indicates that the problem is now at L2-L3 level. Once the initial discectomy was declined at preauth due to absence of EDS findings affecting the L3 nerve root, the third electrodiagnostic "miraculously" finds evidence of L3 radiculopathy – although two prior electrodiagnostic studies found no such findings. I recommend upholding the initial adverse determination. There is no concordance among these symptoms, signs on physical exam, electrodiagnostic studies, and imaging to warrant the requested L2-L3 discectomy. Also some of the diagnostic studies performed –especially the last electrodiagnostic study – appears suspect. This request is outside of Official Disability Guidelines (ODG) recommendations once all the medical records and all the diagnostic studies are reviewed. I spoke to Dr. He was not able to tell me how prior electrodiagnostic studies would fail to reveal L3 radiculopathy, but the third electrodiagnostic study performed after the preauth request of L2-L3 discectomy was submitted found an L3 radicular process. Also no medical rationale provided why we should believe the conclusions of the third electrodiagnostic study as opposed to the conclusions of the first two electrodiagnostic studies.*

Per DWC PLN-11 report, entitlement of medical treatment for laminectomy at L4 and L5 and posterior fusion from L4 through S1 is being disputed. Only lumbar sprain/strain has been accepted as compensable.

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

Medical material reviewed listed numerically included:

1. Patient clinical summary for or by 2. Employers First Report of Injury or Illness xx/xx/xx with a physical performance test
3. Examination records of 5/7/2008
4. 2/5/2008 note by, D.O., and also reports by the same doctor on 2/11/2008, 2/12/2008, 2/18/2008, 2/25/2008
5. Lumbar CT scan report 2/11/2008 by, M.D.
6. 2/12/2008 consultation report by, M.D., and also reports by the same doctor on 2/22/2008, 3/12/2008, 4/2/2008, 5/5/2008, 5/19/2008, 6/3/2008
7. Electrodiagnostic testing report on 4/7/2008 by and one on 5/27/2008 also
8. Lumbar CT myelogram report of 4/17/2008
9. Op report regarding epidural steroid injections on 4/30/2008
10. Behavioral medical consultation report on 5/4/2008
11. adverse decision reports of 5/5/2008 and 6/6/2008

This case involves a now xx year old male who on xx/xx/xx developed sharp pain in his low back when lifting a case of orange juice. The pain soon was associated with some left lower extremity pain. There was numbness and tingling into the left foot. There was history of lumbar surgery on multiple occasions with the final result of that previous surgery being fusion from L4 through S1. The patient was

doing well following the surgery when he developed his recurrent symptoms with the xx/xx/xx injury. Physical therapy, medications, and epidural steroid injections have not been successful in dealing with this trouble. Diagnostic testing has included CT myelography on 4/17/2008 which suggested a left sided L2-3 disc rupture with nerve root compression. A similar finding was encountered on a 2/11/2008 CT scan and repeat electrodiagnostic testing suggests L3 nerve root compression as a new finding in addition to the old findings of L5 radiculopathy.

I disagree with the denial for the proposed operative procedure. The patient has symptoms and findings on various tests that suggest that it is medically probable that his difficulty could be improved by removal of the disc herniation at the L2-3 level on the left side. One of the denial reports indicated that the L3 finding on the EMG was not seen on the initial study. That is not at all unusual because the passage of time is frequently required for the findings to be positive after nerve root compression occurs.

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**

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**