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AMENDED
March 17, 2008

Notice of Independent Review Decision

DATE OF REVIEW: MARCH 12, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Decompression at L1-S1 (Inpatient surgery).

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)

Medical documentation does not support the medical necessity of the decompression at L1-S1 (Inpatient surgery) and Cybertech TLSO back brace.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office notes (1/9/07 – 01/09/08)

M.D.

- Office notes (05/09/07 - 01/31/08)
- Radiodiagnostics (08/07/01)

ODG guidelines Treatment in Worker's Comp 2007 Updates, (1c Low Back-Discectomy/Laminectomy and Back Braces) and ODG indications for Surgery – Discectomy/laminectomy were used in denials

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx-year-old male who was walking out of a building and slipped while stepping down from concrete steps onto a sidewalk on some kind of a welcome mat falling forwards, twisting and landing on the left side of his low back, hip and knee. The injury was reported in xxxx.

On xx/xx/xx, MRI of the lumbar spine was obtained for persistent back pain, radiculitis/radiculopathy. The MRI revealed hemilaminectomy on the left at L5-S1, recurrent disc herniation with some scar formation in the central and on the left at L5-S1 with slight displacement of the left S1 nerve root, central disc herniation at L3-L4 and L4-L5 disc spaces with diffuse disc bulge obliteration of the epidural fat and compression of the thecal sac; and moderate degree of central spinal canal, lateral recess and foraminal stenosis at L3 –L4, and L4-L5 levels. There is no treatment history available from xx/xx through xx/xx.

In May 2007, , M.D., noted the following treatment history: *Subsequent to the injury, the patient underwent a total left knee replacement in October 2001. He had a hemiarthroplasty of his left shoulder in July 2002. In November 2002, , M.D., performed laminectomies and foraminotomies at L2, L3, L4, and L5. The patient did well approximately for six months and thereafter was managed with medications. He had had a prior hemilaminectomy on the left at L5 and S1 in 1993. X-rays in March 2007 revealed a huge osteophyte out to the right at L2-L3, apex of some scoliosis to the right and significant disc space narrowing at L2 –L3, L4-L5 and L5-S1. Dr. performed epidural steroid injections (ESIs) x2. Dr. diagnosed chronic lumbar radicular symptomatology, multilevel spondylosis, status post decompressive laminectomies, and probable residual/recurrent spinal stenosis. He obtained lumbar myelogram/computerized tomography (CT) which showed multilevel spondylosis with spinal stenosis from L1 through S1, spontaneous fusion of the interspace at L5-S1 and with a large anterior osteophyte; a mass on the left side at L5-S1 pushing the left side nerve root posteriorly at L5, lateral recess stenosis on the right greater than the left at L4; significant lateral recess stenosis at L3, L2-L3 and a huge osteophyte out to the right; sclerosis extending through the endplates at L3-L4, and L2-L3; central stenosis and again at L1-L2; and severe disc space narrowing at L4-L5. The patient was treated with two caudal ESIs by, M.D., and was maintained on Oxycodone, Flexeril, and Neurontin. Dr. stated he would proceed with the third ESI only if the pain returned.*

Dr. discussed treatment alternatives of repeat ESI three to four times a year versus surgical intervention for the residual spinal stenosis at the lower three lumbar segments. The patient opted for the surgery. In a psychological evaluation, Dr., stated although there were minimal psychological factors present, the patient would make a good surgical candidate.

On February 7, 2008, the surgery was denied. The rationale was: *there are further office visits from Dr. on November 7, 2007, and January 9, 2008, documenting his complaints, findings, and treatment to include medications and activity modification. He continues to have complaints and at the time of his January 9, 2008 visit, they discuss surgery for decompression from L2 through S1 without fusion. There was then a January 31, 2008, psychological evaluation that felt he was a good surgical candidate. At this time, Dr. has requested an L1 through S1 decompression with two days length of stay. While I understand the patient has abnormal diagnostic studies with foraminal encroachment and*

degenerative change, my concern is that a multilevel decompression like this may cause instability. The records seem to indicate back pain as well as claudication symptoms, and so in this case, I am concerned that just doing a decompression in multiple levels may, in fact, not be the answer to this claimant's problems. Therefore, it is not clear to me that only doing a multilevel decompression is reasonable and necessary, and he may in fact need a higher level of surgery at this time.

On February 19, 2008, reconsideration/appeal of adverse determination indicated denial of the procedure/treatment as medically necessary for the following reason: *The ODG recognizes the possibility of increased instability of the spine after surgical decompression and also states fusion is supported for revision surgery for failed previous operation(s) if significant functional gains are anticipated. There is no indication in the medical records of symptomatic neurologic claudication secondary to stenosis. I agree with Dr. that instability could develop with the proposed revision surgery. Therefore, my recommendation is to non-certify the request for appeal inpatient length of stay two days for posterior decompression L1-L2 with additional levels L2-S1.*

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

Medical material reviewed and listed numerically included:

1. A patient clinical history summary
2. Lumbar MRI report of xx/xx/xx by, M.D.
3. A May 9, 2007 initial chart note by, M.D.
4. Short notes by, M.D., on August 27, 2007, November 7, 2007, and January 9, 2008.
5. Psychological evaluation report on January 31, 2008, by, Ph.D.
6. Inc. Utilization Review determination of February 7, 2008, and February 19, 2008.

This case involves a now xx-year-old male who was injured in a fall on xx/xx/xx. He landed on his left knee and twisted his back. He developed back pain and knee problems, which required total knee replacement in October 2001. His back and lower extremity discomfort was dealt with by L2, 3, 4, and 5 laminectomies in November 2002 with only transient six months improvement. He has been taking medications for pain since that time. The only MRI report is on xx/xx/xx showing multiple areas of degenerative disc disease change and recurrent disc rupture at L5-S1 on the left. There are no more imaging studies reports available, but there is an interpretation that is present by Dr. on the May 10, 2007, CT myelogram of the lumbar spine. There have been epidural steroid injections on two occasions with only transient help.

I agree with a denial for the rather extensive lumbar decompressive operation. There has been previous decompression at essentially the same levels, with only transient relief and I think transient relief would be the only thing that one could expect from repeat of that procedure. Scar formation and continued bone change probably accounts for the recurrence of discomfort, which almost invariably occurs after such an operation. Because of the transient relief these operations have been pursued on three to four occasions with only the transient benefit they obtained. In addition, there is nothing new

in regards to neurological deficit which would indicate decompression of the nerves would be helpful. A more thorough pain management evaluation would be more indicated than the proposed operative procedure.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- Guidelines developed by the reviewer over 38 years of evaluating spinal surgical problems**