

# MATUTECH, INC.

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**DATE OF REVIEW:** November 14, 2008

**IRO CASE #:**

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

Inpatient lumbar surgery: Examination under anesthesia, revision lumbar spine surgery, decompression, arthrodesis with cages, posterior instrumentation, implantation of a bone growth stimulator – L4 transitional level.

**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 Inpatient lumbar surgery: Examination under anesthesia, revision lumbar spine surgery, decompression, arthrodesis with cages, posterior instrumentation, implantation of a bone growth stimulator – L4 transitional level.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Utilization reviews (10/14/08 – 10/27/08)

M.D.

- Office visits (06/28/07 - 09/23/08)
- RME (11/17/06)
- Diagnostics (07/09/07)
- Physical therapy (07/15/08 – 08/22/08)
- Utilization reviews (10/14/08 – 10/27/08)
  
- Office visits (06/28/07 - 09/23/08)
- RME (11/17/06)
- Diagnostics (07/09/07)
- Physical therapy (07/15/08 – 08/22/08)

- Utilization reviews (10/14/08 – 10/27/08)

#### Attorney at Law

- Office notes (05/30/06 – 09/23/08)
- Therapy sessions (06/02/06 – 08/22/08)
- Diagnostics (06/07/06 – 03/29/08)
- Injections (06/22/06 – 10/17/07)
- RME (11/17/06)
- Surgeries (12/06/06 and 05/20/08)
- Designated doctor evaluations (05/05/07 – 04/21/08)
- FCE (09/09/08)
- IR evaluation (09/18/08)
- Utilization reviews (10/14/08 – 10/27/08)

ODG have been utilized for denials.

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

The patient is a xx-year-old male who was injured on xx/xx/xx, when he slipped and fell injuring his low back and right leg.

Following the injury, M.D., evaluated the patient for right low lumbar pain with radiation in the right leg down to lateral foot. He noted a positive straight leg raising (SLR) on the right. X-rays of the lumbar spine were unremarkable except for degenerative joint disease (DJD) and transitional lumbosacral vertebra. Dr. assessed lumbosacral strain and lumbar radiculopathy and treated him with Motrin, Flexeril, Biofreeze, naproxen, Zanaflex, and Lortab, and physical therapy (PT).

Magnetic resonance imaging (MRI) of the lumbar spine revealed multilevel spondylosis and degenerative disc disease (DDD). These changes were most prominent at L4-L5 with a right paramedian disc extrusion extending approximately 8 mm caudally and posteriorly to the L5 vertebral body. This appeared to impinge upon the descending right L5 nerve root within the lateral recess. There was associated central canal stenosis. Spondylotic disc bulges extended into caudal aspect of both neural foramen and indenting upon the exiting bilateral L4 nerve roots, right greater than left.

D.O., a pain specialist, felt the patient had very symptomatic right-sided radiculopathy. He performed a series of three lumbar epidural steroid injections (ESIs). With the first ESI, the patient reported 60% improvement but he did not improve with the second and the third ESI.

Per DWC PLN 11 report of July 18, 2006, lumbar DDD was disputed.

M.D., an orthopedic surgeon, saw the patient for persistent low back and right leg pain. Examination revealed weakness of the right extensor hallucis longus (EHL), decreased sensation in the right L5 dermatome, and positive SLR on the right. He assessed herniated nucleus pulposus (HNP) on the right at L4-L5 with L5 radiculopathy and lumbar spondylosis. He recommended microscopic decompression and discectomy at L5-S1.

M.D., performed a required medical evaluation (RME) and rendered the following opinions: (1) The diagnosis would be herniated disc at L4-L5. He had some age-related degenerative findings in the low back that were not excessive. He got a clear cut L4-L5 herniation superimposed on degenerative changes. (2) The effects of the injury had not resolved. The medical care rendered had been reasonable. (3) The patient was a surgical candidate for L4-L5 herniated disc and L5 radiculopathy. (4) He was not capable of working. (5) The ongoing prescription medications were reasonable. (6) The compensable injury did not extend to include psychiatric diseases or treatments.

On December 6, 2006, Dr. performed microscopic hemilaminotomy at right L4-L5, decompression of right L5 nerve root, and discectomy of L4-L5 disc on the right.

The patient attended postoperative PT which made him worse. He had some numbness in the right leg, mainly along the dorsum of the right foot. Dr. recommended electromyography/nerve conduction velocity (EMG/NCV) study of the lower extremities and functional capacity evaluation (FCE).

In May 2007, M.D., a designated doctor, did not place the patient at maximum medical improvement (MMI) and felt that the patient would benefit from neurology consultation and EMG/NCV study of the right leg. He stated that the patient was currently unable to return to work at any capacity.

The patient was seen by multiple physicians at Medical Centers for medication management.

Dr. assessed right facet joint syndrome and chronic low back pain, prescribed Vicodin and Mobic, and recommended a trial of facet joint injections. EMG/NCV study revealed acute right L5 and S1 motor radiculopathy. Dr. performed an ESI at L5-S1 and later a right L5 selective nerve root block. The patient had no relief with these and was recommended medial branch blocks of the facet joints.

In 2008, it was noted that the patient had started working in light duty and his pattern of symptoms was stable on medications. A repeat MRI of the lumbar spine revealed persistent multilevel spondylosis and DDD throughout the thoracolumbar spine. The disc extrusion at L4-L5 was not identified; however, circumferential disc bulging and bilateral facet arthropathy were causing severe central canal stenosis which measured approximately 5.5 in anterior to posterior dimension. There was bilateral lateral recess stenosis and neural foraminal stenosis at this level.

M.D., a designated doctor, opined: (1) The patient was not at MMI and further improvement could be expected if the patient had decompressive surgery at L4-L5. (2) He could work in a sedentary or light duty not lifting more than 20 lbs. Even if he had a good result postoperatively, his future work ability would not be better than, perhaps, lifting 20-40 lbs frequently. (3) The microdiscectomy in December 2006 failed to relieve the spinal canal stenosis that was likely pre-existing at L4-L5 due to osteoarthritis and spondylosis. The current stenosis would require another surgery.

Dr. re-evaluated the patient for soreness in the back and numbness, pain, and tingling in the right leg. Fresh x-rays of the lumbar spine were obtained, which revealed no instability. Dr. stated that the patient's symptoms were consistent with neurogenic claudication and the MRI had revealed severe central canal stenosis at L4-L5. He recommended redo open decompression and foraminotomies at L4-L5.

On May 20, 2008, Dr performed redo laminectomy at L4-L5 bilaterally, partial fasciectomy at L4-L5 bilaterally, decompression with neurolysis of L5 nerve roots bilaterally, foraminotomies at L5 bilaterally, and redo discectomy at L4-L5 on the right. The patient developed two draining fistulas in the upper incision and was treated with antibiotics. He attended 12 sessions of therapy but felt that he was not benefited by the surgery. Dr. obtained x-rays which did not show any instability at L4-L5 but osteophytes were noted anteriorly at L2-L3, L3-L4, and L4-L5. He felt the patient was not a surgical candidate and referred him for assessment of MMI and impairment rating (IR).

In an FCE, the patient qualified at a sedentary-to-light physical demand level (PDL) against a very heavy PDL required at job. The evaluator recommended work conditioning/work hardening (WC/WH) to assist him to return to a job with light-to-medium PDL if possible. In an IR evaluation, D.C., noted the patient had continued to suffer from chronic back pain radiating to the right leg. The patient also suffered from urinary difficulties, erectile dysfunction, and numbness in the right hand and arm. Dr. assessed statutory MMI as of June 13, 2008, and assigned 10% whole person impairment (WPI) rating.

On September 23, 2008, M.D., an orthopedic surgeon, evaluated the patient for surgical evaluation and flexion/extension x-rays to delineate the instability pattern, if present, to assist with impairment rating (IR) process. Examination revealed positive Spring test at the interiliac crest line, positive sciatic notch tenderness on the right, equivocal 14 finger test on the right, and positive extensor lag. There was positive flip test on the right, positive Lasegue's on the right at 45 degrees, positive Braggard's, decreased ankle jerk on the right, absent posterior tibial tendon jerk bilaterally, paresthesias in the L5-S1 nerve root distribution on the right, and weakness of gastroc soleus on the right. X-rays of the pelvis revealed hips without degenerative joint disease (DJD) and sacroiliac (SI) joints without sclerosis. The patient had four lumbar appearing vertebrae and a transitional vertebra. X-rays of the lumbar spine to include flexion/extension views revealed L4 transitional extension angle measuring 15 degrees with anterior longitudinal ligament ossification extending up into the next level with spondylosis and decompression. Dr. stated this indicated an instability pattern according to the American Academy of Orthopedic Surgeons' instructional course letters and the American Medical Association Guides for Evaluation of Permanent Impairment, IV edition. He assessed failed lumbar spine syndrome with clinical instability, right radiculopathy, and failure of conservative treatment and recommended surgical correction including stabilization at the last open segment or L4 transitional. The list of proposed surgery included examination under anesthesia (22899), lumbar laminotomy (hemilaminectomy)/discectomy (63042), additional level decompression (63011), microdissection technique (69990), discography (62290), lateral arthrodesis (22612), application of intervertebral biomechanical device (22851), bone graft (20938), posterior non-segmental instrumentation (22840), anterior lumbar

arthrodesis (22558), use of invasive electrical stimulator (20975), implantation of EBI stimulator (63685), and reduction of surluxation of L4 transitional vertebra (22325). The expected length of stay was two days.

On October 14, 2008, M.D., denied the requested services with the following rationale: *“He was diagnosed as having an L4-L5 herniation and subsequently underwent two decompressive procedures, the most recent in 2008, the exact date, which is not known. It appeared that he developed drainage afterwards. The extent of the infection was not documented. There is insufficient information to determine if the fusion is indicated. This reviewer does not know if the infection has been adequately cared for. The indication for the stimulator was not outlined. There is no documentation of a multilevel fusion or a smoking history. It was noted in the record review that the L4 extension angle measured 15 degrees. There was no documented translational instability with flexion/extension views. With the limited information proved, this reviewer would not certify the procedure. The extent of conservative treatment also was not outlined. Based on the clinical information submitted for this review and using the evidenced-based peer reviewed guidelines referred above, the request for L4 fusion/decompression/arthrodesis with cages/instrumentation/bone growth stimulator implant/two days length of stay is not recommended.”*

On October 27, 2008, , M.D., denied the appeal for the lumbar surgery with the following rationale: *“While noting the claimant does have a long history of multiple back surgeries, there is no objective evidence of instability, fracture, or infection at this time. This would discount a surgical intervention with fusion. Based on the clinical information submitted for this review, and using the evidenced-based peer reviewed guidelines referenced above, this request for L4 fusion/decommission/arthrodesis with cages/instrumentation/bone growth stimulator implant/two days length of stay is not medically necessary.”*

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

**MEDICAL MATERIAL REVIEWED LISTED NUMERICALLY:**

1. PATIENT CLINICAL SUMMARY FROM MATUTECH
2. MEDICAL CENTER REPORTS FROM 5/30/06 THROUGH MULTIPLE DATES TO 8/21/08
3. 6/22/06 PAIN MANAGEMENT REPORT BY D.O., AND ALSO REPORTS BY THE SAME DOCTOR ON 8/7/06, 9/1/06
4. 11/17/06 HISTORY AND PHYSICAL REPORT BY , M.D.
5. 12/6/06 OPERATIVE REPORT REGARDING A RIGHT L4-5 DISCECTOMY BY DR.
6. ELECTRODIAGNOSTIC TESTING REPORT 7/9/07 BY , D.O.
7. 5/20/08 OPERATIVE REPORT FOR A REDO LAMINECTOMY BY DR.
8. 8/26/08 OFFICE VISIT REPORT BY DR.
9. OFFICE VISIT REPORT BY M.D., 9/24/08
10. 10/27/08 DETERMINATION LETTER FROM , M.D.

**THIS CASE INVOLVES A NOW XX YEAR OLD MALE WHO ON XX/XX/XX SLIPPED AND FELL. HE DEVELOPED LOW BACK PAIN WITH EXTENSION INTO THE RIGHT LOWER EXTREMITY. FOLLOWING THAT AND DESPITE MEDICATIONS AND PHYSICAL THERAPY HE CONTINUED WITH HIS**

DISCOMFORT. AN MRI SHOWED RIGHT L4-5 DISC RUPTURE AND AFTER THAT WAS PERFORMED EPIDURAL STEROID INJECTIONS WERE TRIED ON THREE OCCASIONS WITHOUT SIGNIFICANT HELP. EXAMINATION AND THE MRI WERE COMPATIBLE WITH L5 NERVE ROOT COMPRESSION SECONDARY TO DISC HERNIATION SO ON 12/6/06 A RIGHT L4-5 DISCECTOMY WAS CARRIED OUT. THE PATIENT DID POORLY POSTOPERATIVELY WITH CONTINUED PAIN AND NUMBNESS AND WAS ABLE ONLY TO RETURN TO LIGHT DUTY. ELECTROMYOGRAPHIC EVALUATION ON 7/9/07 SHOWED A RIGHT L5-S1 RADICULOPATHY. A REPEAT MRI SUGGESTED SEVERE STENOSIS AT THE L4-5 LEVEL WITH THIS LEVEL NOW BEING REFERRED TO AS L4 TRANSITIONAL BECAUSE THE L5 WAS THOUGHT TO BE A TRANSITIONAL VERTEBRA. ON 5/28/08, A REDO LAMINECTOMY WITHOUT FUSION WAS CARRIED OUT. POST OPEATIVE INFECTION OCCURRED. AN AUGUST 2008 NOTE BY DR. INDICATED THAT NOTHING MORE IN THE WAY OF SURGERY WAS THOUGHT INDICATED BUT A NOTE IN SEPTEMBER 2008 BY DR. RECOMMENDED THAT ANOTHER SURGICAL PROCEDURE INCLUDING FUSION BE CARRIED OUT ON HIS LUMBAR SPINE. AFTER HIS SECOND LUMBAR SURGERY THERE WAS SIGNIFICANT INFECTION, THE EXACT STATUS OF WHICH IS UNKNOWN AT THIS TIME.

I AGREE WITH THE DENIAL FOR THE PROPOSED RATHER EXTENSIVE OPERATIVE PROCEDURE ON THE LUMBAR SPINE. THE PATIENT HAS BEEN ONLY 6 MONTHS SINCE HIS LAST SURGERY AND I THINK MORE TIME AND POSSIBLY ADDITIONAL TESTING SHOULD BE CARRIED OUT BEFORE ANY MAJOR PROCEDURE SUCH AS THAT PROPOSED IS UNDERTAKEN. ADDITIONAL TESTING MIGHT INCLUDE LUMBAR CT MYELOGRAPHY WITH FLEXION AND EXTENSION VIEWS TO DETERMINE THE DEGREE OF INSTABILITY AND THE LEVELS OF POSSIBLE INSTABILITY BEFORE ANY MAJOR PROCEDURE ON THE LUMBAR SPINE INCLUDING POSSIBLE MUTLIPLE LEVEL FUSION IS CARRIED OUT. IN REGARD TO THE INSTABLITY, THERE SEEMS TO BE A DIFFERENCE OF OPINION IN REGARD TO THE INSTABILITY AND BE THAT AS IT MAY IF THERE IS INSTABILITY IT IS EXTREMELY MINOR. TO SUBJECT SOMEONE TO THE PROPOSED OPERATIVE PROCEDURE OF ANTERIOR AND POSTERIOR SURGERY WITH HARDWARE INTRODUCTION IN THE FACE OF FAIRLY RECENT INFECTION AND WITH NOTHING NEW IN THE WAY OF FINDINGS IS NOT INDICATED.

**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**