

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** July 31, 2009

**IRO CASE #:**

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

Bilateral lumbar laminectomy/discectomy at L4-S1, LOS x 2 days

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

Certified, American Board of Orthopaedic Surgery

**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 health care services in dispute.

**ODG criteria have been utilized for the denials.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a xx-year-old who lifted a heavy box containing candy weighing approximately 80 lbs and felt sudden sharp pain in his back.

On xx/xx/xx, M.D., performed bilateral L4-L5 partial laminectomy with discectomy and bilateral L5-S1 partial laminectomy. From September through December 2008, the patient was seen by M.D., for pain management and refill of intrathecal narcotic pump on a monthly basis. Past treatment included lumbar epidural steroid injection (ESI). He was on Phenergan, Vicodin, and Keflex. Dr. diagnosed failed back syndrome and chronic intractable low back pain and prescribed Peri-Colace. The patient continued to complain of low back pain with referred pain to the right thigh and occasional intermittent left lower extremity pain and weakness in his right leg as compared to the left. The pump medications were changed in July 2008 from morphine to Dilaudid. His daily dosage was increased to 3.5 mg of Dilaudid to which he developed an adverse reaction. He complained of continued urinary retention and constipation and difficulty emptying his bladder since placement of the pump. His problems continued to persist and hence consultation with a urologist was requested. He

had his prostrate evaluated by his primary care physician and no abnormalities were found. Dr. prescribed HCTZ, a mild diuretic; Senna-S for constipation; and Xodol for pain.

In 2009, computerized tomography (CT) scan of the lumbar spine demonstrated a wide posterior decompressive laminectomy defect at L4-L5 with posterior spondylosis and 7-mm broad-based disc protrusion causing impression upon the ventral aspect of the thecal sac as well as mild lateral recess stenosis with posterior displacement of the proximal left L5 root. A broad-based 5 mm or 6 mm posterior disc protrusion was seen at L5-S1 with contact of the ventral thecal sac and both proximal S1 roots and mild foraminal narrowing with displacement of the emanating L5 root.

M.D., a spine surgeon, evaluated the patient for ongoing central low back pain radiating down the lower extremities towards the feet associated with numbness and tingling. The patient had been previously treated with physical therapy (PT) and work hardening program (WHP). X-rays of the lumbar spine were unremarkable. Dr. assessed chronic low back pain with evidence of disc herniation at L4-L5 and L5-S1 and urinary retention associated with intrathecal morphine (rule out thecal sac compression given the history disc herniation). He recommended a CT myelogram of the lumbar spine and evaluation of urinary retention by a urologist.

In May, Dr. noted the patient's last magnetic resonance imaging (MRI) had shown evidence of two large herniated discs at L4-L5 and L5-S1. Dr. refilled the pump and referred him to Dr. for surgical consultation.

A lumbar myelogram showed subtle ventral extradural defects at L4-L5 and L5-S1. Post-myelogram CT scan showed large chronic subligamentous disc herniation at L4-L5 and L5-S1, mild bilateral neural foraminal stenosis at L4-L5, and intrathecal infusion catheter placement at L1-L2. After reviewing the findings, Dr. recommended a laminectomy and discectomy with removal of centrally extruded disc herniation at the L4-L5 and L5-S1 levels.

On June 11, 2009, the request for bilateral lumbar laminectomy/discectomy at L4 through S1 with two days length of stay was denied by M.D., an orthopedic surgeon. Rationale: *"The patient is noted to have sustained a lifting injury to the low back in xx/xx. The patient underwent L4-L5 laminectomy with some improvement in symptoms. The patient subsequently underwent insertion of pain pump in March 2008 for intractable low back pain. The patient currently complains of low back pain radiating down both lower extremities. CT scan revealed postoperative changes at L4-L5. There are posterior disc protrusions noted at L4-L5 and L5-S1 with posterior displacement of the left L5 nerve root and contact of both proximal S1 roots. However, on clinical examination the patient has no evidence of neurologic deficit. Neurologic testing was reported to be entirely within normal limits with respect to motor power, dermatomal sensation, and deep tendon reflexes (DTRs). There were no root nerve tension signs. Straight leg raise (SLR) was negative."*

On July 2, 2009, M.D., denied the reconsideration of bilateral lumbar laminectomy. He noted the patient had undergone prior surgery at L4-L5 and L5-S1. He had ongoing complaints of pain at least back to 2007. He had

undergone pain management. There were underlying issues of depression. He underwent placement of morphine pump. Dr. provided the following rationale: *“A peer-to-peer discussion did not occur for the recommended bilateral lumbar laminectomy. Based on the medical records provided the indications for the procedures are not adequately outlined. The patient underwent a previous decompression. He also has a morphine pump. It appears based on the information that his symptoms are chronic. There is limited information on conservative treatment. It is unclear if any physical therapy was attempted, psychological screening completed for the morphine pump trial but it is unclear if there was a psychological screening for the surgery. Therefore, based on ODG guidelines and evidence-based medicine the requested surgery and a two-day length of stay would not be indicated. The use of a lumbar corset would also not be indicated. Based on ODG guidelines, lumbar supports are not recommended for prevention and they are under study for treatment of non-specific low back pain. They are recommended for fractures, instability and postoperative treatment but, there is evidence that lumbar supports are not effective in preventing back pain and are not recommended for chronic mechanical back pain. These would also lead to further weakness. Therefore the request for a lumbar corset is also not medically indicated.”*

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

On 11/19/04, Dr. took the patient to surgery, the indications being unknown. He performed bilateral partial laminectomies at L4-5 and L5-S1. He noted only a central disc herniation at L4-5, for which a discectomy was performed. There was only a bulge at L5-S1, so no discectomy was performed at that level. There is no indication in the operative report that there was any evidence whatsoever of lateralization, neuroforaminal compromise, or direct nerve root compression.

Since surgery, the patient has fared poorly, having been diagnosed with failed back surgery syndrome, and has failed extensive nonsurgical treatment, and has failed an intrathecal pain pump.

The most recent MRI and CT-myelogram identified “large” and “chronic” subligamentous disc herniations at L4-5 and L5-S1 without evidence of lateralization, neuroforaminal compromise, or direct nerve root compression. The nerve root sleeves filled normally and symmetrically on the myelogram. X-rays revealed no evidence of instability.

The current request for 2-level laminectomy and discectomy appears to lack sufficient medical rationale and does not meet ODG criteria. The surgery being recommended is the exact same procedure that was performed previously that produced the iatrogenic sequelae of failed back surgery syndrome, which in-and-of-itself is a relative contraindication for further spinal surgery. There is no evidence of disc lateralization, neuroforaminal compromise, or direct nerve root compression--the actual pathoanatomic entities that may be positively affected by removing the mechanical impingement of a symptomatic disc herniation. There simply is insufficient evidence-based rationale to remove a disc bulge or subligamentous chronic herniation just because it is there. This was attempted previously, and has been proved a dismal failure.

With regard to the imaging studies, there is insufficient evidence of an acute, focal pathoanatomic lesion that may be directly attributed to the MOI, the initial presenting symptoms, the interval history, or pertinent positive physical exam findings (or lack thereof). Evidence-based musculoskeletal literature is replete with evidence that many persons in this age group may have significant appearing “abnormal” findings on imaging studies, yet may be *completely asymptomatic*. Such “abnormal” findings may even evolve over time, appearing to improve, worsen, or even change levels. Therefore, careful clinical correlation must be consistently established based on specific nerve root-level clinical findings. Such correlation is not evident in the documentation herewith.

Furthermore, ODG clearly requires pre-operative psychological screening. Considering the psychological state of patients experiencing chronic pain, depression, and the multitude of other psychosocial stressors inherent to work-comp claims, it would appear to have been obvious to obtain this evaluation prior to even considering surgical intervention.

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**