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Notice of Independent Review Decision

DATE OF REVIEW: November 29, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left L5-S1 discectomy

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

**Diplomat, American Board of Orthopaedic Surgery
Fellowship trained in spine 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Dr.

- Diagnostics (01/19/10 – 04/21/10)
- Office Visits (04/28/10 – 09/14/10)
- Reviews (05/28/10)
- Utilization review (09/23/10 – 09/28/10)

TDI

- Office visits (01/18/10 – 09/14/10)
- Diagnostics (01/19/10 – 04/21/10)
- Reviews (05/28/10)
- Utilization review (09/28/10 – 11/16/10)

[ODG has been utilized for the denials.](#)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who injured herself on xx/xx/xx, while moving a patient for a bone density test. She felt a twinge in her low back, but was unable to walk four days later.

She was evaluated by M.D., for low back pain with numbness and tingling in her buttocks with weakness in her right leg as well as some tingling on the left. Following that she transferred her care to, M.D., and was on pain medications since then. An attempt was made to resolve the lower extremity radiculopathy with epidural steroid injection (ESI) performed by Dr. at Diagnostic Center, which however failed. She had concluded six physical therapy (PT) sessions without any positive outcome. She continued to have significant pain with radiation to her lower extremities associated with tingling and numbness. Her ongoing medications included Lortab, Neurontin, temazepam and Lyrica. The patient was referred for orthopedic and spine consultation.

Magnetic resonance imaging (MRI) of the lumbar spine revealed disc desiccation at the L5-S1 level with a diffuse disc bulge and a central disc protrusion producing mild central canal stenosis and mild right neural foraminal stenosis. Electromyography/nerve conduction velocity (EMG/NCV) study of the lower extremities revealed acute left L5-S1 radiculopathy.

Designated doctor M.D., deferred assessment of maximum medical improvement (MMI) on May 28, 2010, and released her to work with restrictions.

M.D., an orthopedic surgeon, noted 75% of low back pain, 25% of left leg pain and right hip pain. Exam revealed mild soft tissue pain with palpation and restricted range of motion (ROM), positive straight leg raise (SLR) on the left and painful toe and heel walk. He assessed displacement of lumbar intervertebral disc without myelopathy and radiculopathy and recommended a left L5-S1 discectomy.

On September 28, 2010, the request for left L5-S1 discectomy was denied with the following rationale: *“Most recent MD note is September 14, 2010. MRI from January 2010 shows disc bulges without significant neurocompressive pathology. Physical exam findings are suggestive of a radiculopathy. However, MRI does not confirm any neurocompressive pathology. Given the lack of MRI findings coupled with significant findings of advancing motor or neurologic deficits, request not medically necessary”*.

Dr. requested a reconsideration stating that EMG/NCV study revealed a positive radiculopathy at L5-S1. In addition, the patient had absent reflexes with sensory deficits on clinical examination. She had undergone six sessions of PT followed by a trial of lumbar ESI. Despite the interventional pain procedure the pain level was persistent with sharp shooting radiation to the left lower extremity. He opined that patient qualified for a lumbar hemilaminectomy and discectomy at left L5-S1 to resolve her lower extremity radiculopathy.

On November 1, 2010, the denial was upheld. Rationale: *“The submitted clinical records indicate the claimant has undergone MRI of the lumbar spine on 01/19/10 which showed evidence of disc desiccation and diffuse bulge without any central canal or neural foraminal stenosis or neural impingement. The claimant is reported to have undergone at least 12 sessions of physical therapy*

and chiropractic treatment. Per the clinical record, there is suggestion the claimant underwent LESI in 08/10; however, no clinical records were provided to support the failure of conservative treatment and to document performance of lumbar ESI. Records indicate there are clear inconsistencies between evaluating providers without significant findings documented on designated doctor evaluation (DDE). It is further noted and opined that the claimant has left lower extremity radiculopathy by both physical examination and EMG/NCV. The EMG/NCV study is not valid noting it was performed by technician and read off site. As such, the validity in the performance of this study cannot be established; therefore, it is excluded data in consideration of this request. Given the lack of correlation between imaging, subjective reports, and objective findings as well as lack of documentation to establish failure of conservative treatment, the request is not established as medically necessary”.

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

I have had the opportunity to review the forwarded records on the patient. This xxx had a work injury on xx/xx/xx, when she was moving. She felt a twinge into her low back. She had subsequent difficulty walking four days later. The records for review include that of the evaluation by Dr. (M.D.), on. He stated that there was numbness and tingling reported in her buttocks and weakness into her right leg. She had small amount of tingling onto the left side. She had a normal gait and she had normal reflexes at the knee and ankle. There was some mild straight leg raise bilaterally but her strength was normal.

She underwent an MRI at the Clinic on January 19, 2010, read by, M.D. At the L5-S1 level, there was noted disc desiccation and diffuse disc bulge and a central disc protrusion producing a mild central canal stenosis and mild right neural foraminal stenosis, but no indication of nerve root entrapment.

On April 21, 2010, there was electrodiagnostic interpretation by Dr. (M.D.), who was not present for the test but the test report stated that he was available by secure video and audio web-conferencing.

The electromyography sampled approximately five muscle groups including the paraspinals. Based on the paraspinals allegedly showing positive sharp waves the patient was diagnosed with a left L5-S1 radiculopathy.

The patient came under the care of Dr.. The evaluation of April 28, 2010, reported that the back pain could go up to a 7 on a 10 scale. It was noted that there was low back pain radiating in bilateral buttocks. She also had tingling and numbness reported. She was on medications of Lortab 10/500 one every 8 hours. She was also given piroxicam and Lyrica. The lumbar spine evaluation neurologically showed muscle strength graded at 4/5, although no dermatomal distribution is discussed. Deep tendon reflexes however were 2+ bilaterally in Achilles and patella. The patient was reported to have a positive straight leg raise, more so on the left, left side at 25 degrees and right side 35 degrees. There is a blank on this particular exam for a missing data point. Subsequent

office visit on May 12, 2010, by Dr. interestingly has the same missing data point and the physical exam appears to be essentially the same documentation as before. Now Dr. stated there is radiculopathy with weakness to the right lower extremity and that has decreased tendon reflexes in the left S1; however, that is inconsistent with his lumbar spine exam that is documented.

On May 28, 2010, Dr. noted that there was no tenderness to palpation of the lumbar spine in his evaluation as a designated doctor. He did note that the straight leg raising in the supine posture was 55 degrees on the right and 60 degrees on the left although he does not state what that means. Straight leg raising in the sitting position was 80 degrees bilaterally and cross straight leg raising was negative bilaterally. Her knee jerks were 2+ and symmetrical, ankle jerks also 2+ and symmetrical without clonus. There is no indication that he reviewed the actual MRI but he made a diagnosis of L5-S1 herniated nucleus pulposus with left radiculopathy of S1.

Dr. on August 4, 2010, stated the patient had significant herniation with EMG positive for an acute right L4 through S1 radiculopathy which is not consistent with the MRI or the aspect of the EMG report by Dr..

The physical exam again has the same data points and the one is missing which appears to be a repeat of the same physical exam that was reported before. He now proposed referral to Dr., a board-certified spine surgeon.

On September 14, 2010, Dr. reports that her pain was 75% low back pain, 25% left leg pain, and right hip pain. The patient reported that she had a significant discomfort with radiation to her lower extremities associated with numbness and tingling. However, no dermatomal distribution is provided.

The physical exam per Dr. showed the gait normal. The toe rise and walking was painful on the left as well as heel walking was painful on the left. The strength in the EHL and gastrocs was reported to be 4/5 on the left and normal on the right. The patellar tendon reflexes were 2+ and the Achilles reflexes were reported absent on the left. Of interest, Dr. reported that the MRI at L5-S1 showed a disc bulge diffuse with central disc protrusion with central canal stenosis and neuroforaminal stenosis. However, he does not describe which foramen was narrowed and that appears to be the right neural foramen per the official report. However, Dr. proposed the left L5-S1 laminectomy and discectomy.

On September 28, 2010, the utilization review result with Dr. indicated that there was a lack of MRI findings of neurocompressive pathology. Thus the request for surgical intervention was not approved. On October 25, 2010, Dr. stated in his reconsideration letter that he agrees that there is no neurocompressive pathology or any displacement of the nerve root on MRI; however, that was the specific reason he asked for an EMG/nerve conduction study on this patient which revealed the patient does have a positive radiculopathy at L5-S1."

The reconsideration on November 1, 2010, was performed by Dr., a board-certified orthopedic surgeon. The patient was considered not to be a candidate for the operative procedure proposed by Dr..

The records indicate a lack of neurocompressive pathology even by Dr. own report in his reconsideration letter. The validity of the EMG nerve conduction as read by Dr. who did not have personal involvement in the examination or the performance of the actual EMG is also of concern not only to the utilization review physician but also to this reviewer. The patient's original symptoms were to the right lower extremity and buttock. The MRI indicates that the neuroforaminal narrowing on the right, not the left. The necessity to perform an L5-S1 decompression and discectomy on this xxx is not validated by these records. Thus the denial of the L5-S1 laminectomy discectomy is upheld.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**