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Notice of Independent Review Decision

DATE OF REVIEW: 12/30/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L3, L4, & L5 laminectomy with length of stay 1 day – 63047 and 63048 x2

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:

Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Diagnostics (08/17/09 - 12/21/09)
- Procedure (10/01/09)
- Review (04/27/10)
- Office visit (11/03/10)
- Utilization review (11/18/10)

Dr.

- Office visit (08/04/09 – 09/27/10)
- Diagnostics (08/17/09 - 12/21/09)
- Procedure (10/01/09)
- Review (04/27/10)

TDI

- Office visit (08/04/09 – 09/27/10)
- Diagnostics (08/17/09 - 12/21/09)
- Procedure (10/01/09)
- Review (04/27/10)
- Utilization review (11/18/10 – 12/10/10)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was throwing some PVC pipes overhead and developed pain in the back on xx/xx/xx.

2009: The patient was seen at by M.D., M.D., M.D., and M.D., for intense pain in the back on the right side radiating down into the buttock to the thigh with occasional paresthesia. Examination showed point tenderness over the right SI joint, slightly limited range of motion (ROM) in all directions due to pain, hypesthesia in the sole of the left foot, positive straight leg raise (SLR) test on the right, tenderness and spasms in the right lumbar paraspinal muscles. X-rays of lumbar spine were unremarkable. The patient was diagnosed with lumbar radiculopathy, lumbar strain, facet arthropathy, hypesthesia of sole of the left foot. He was treated with Medrol Dosepak and Darvocet-N 100 and was recommended ice/cold pack and physical therapy (PT). The patient's condition worsened with PT. He complained of pain radiating down both sides with paresthesia.

Magnetic resonance imaging (MRI) of the lumbar spine showed high-grade canal stenosis of 70-80% at L3-L4 and L4-L5 with lateral recess stenosis at L5-S1 and approximately 20-30% canal stenosis at L2-L3 secondary to facet arthropathy; foraminal encroachment bilaterally at L3-L4, greater on the right, L4-L5 greater on the left, and L5-S1 to a fairly moderate-to-severe degree bilaterally and minimal foraminal encroachment seen on the right at L2-L3. Facet arthropathy was noted at L3-L4 and L4-L5 contributing to canal stenosis at these levels.

In October M.D., performed a lumbar epidural steroid injection (ESI) at L5-S1 on the right side. M.D., noted the patient was status post two ESIs with minimal improvement and referred the patient to a neurosurgeon.

In December, M.D., performed electromyography test nerve conduction (EMG/NCV) of the lower extremities that revealed significant left S1 radiculopathy.

2010: On April 27, 2010, M.D., a designated doctor, opined the patient was not at maximum medical improvement (MMI) and recommended surgical decompression due to poor progress with conservative modalities.

In September, Dr. evaluated the patient for numbness in both legs. She noted the patient had been approved for surgery. She referred the patient to neurosurgeon for possible laminectomy.

M.D., an orthopedic surgeon, evaluated the patient for pain in low back radiating to the lower extremities with numbness and burning in the sole of the feet. Examination showed minimal tenderness over the lumbosacral junction. Dr. assessed lumbar stenosis and radiculopathy and recommended laminectomies at L3, L4, and L5.

Per utilization review dated November 18, 2010, the request for L3, L4, and L5 laminectomy with one day length of stay was denied with the following rationale: *“Based on the medical reports provided, the patient has low back pain experienced more in the legs than the back itself. Physical examination revealed minimal tenderness to palpation over the lumbosacral junction. There is some diminished sensation over the soles of both feet with light touch. MRI showed high-grade canal stenosis of 70-80% at L3-L4 and L4-L5, with lateral recess stenosis at L5-S1 and approximately 20-30% canal stenosis at L2-L3, secondary to facet arthropathy. Foraminal encroachment is seen bilaterally at L3-L4 greater on the right, L4-L5 greater on the left and L5-S1 to fairly moderate-to-severe degree bilaterally. Minimal foraminal encroachment is seen on the right at L2-L3, articular facets show fairly pronounced facet arthropathy at L3-L4 and L4-L5 secondary to the canal stenosis at these levels. Treatment has included ESI and PT; however, there is no clear documentation of at least one symptom/finding (unilateral foot/toe/dorsal flexor weakness/atrophy or unilateral hip/lateral thigh/knee pain) which confirms the presence of radiculopathy and associated clinical findings such as loss of relevant reflexes, muscle weakness and/or atrophy of appropriate muscle groups, loss of sensation in the corresponding dermatomes at the levels requested. The medical necessity of the request has not been established.”*

Per reconsideration request dated December 10, 2010, the request for laminectomy at L3, L4 and L5 with one-day length of stay was denied with the following rationale: *“Based on the medical reports provided, the patient has low back experienced more in the leg than the back itself, however, looking at the most current examination of the back there seems to be no neurologic deficits at all except for the diminished sensation over the soles of the feet with light touch which can be unequivocal. There seems to be some inconsistencies between the neurologic examination and the MRI imaging. The significant central canal and foraminal stenosis which appeared on the imaging studies does not match that of the neurologic findings of the patient. Hence, a more comprehensive neurologic examination should be included in the review. Likewise, there have been no clear and objective documentation regarding the conservative measures employed to the patient in order to alleviate the symptoms. Conservative care has not yet been fully exhausted. Hence, the request for an appeal for an L3-L5 laminectomy is deemed as not medically necessary. Likewise, the one-day length of stay was no medically necessary.”*

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

Mr. is a gentleman who had increased pain into his lumbar spine on xx/xx/xx, when he was at work throwing and lifting PVC pipes overhead. The patient was seen by several providers at with noted symptoms into the back but also into the buttock and down the leg, more on the right side with paresthesia. There was a positive straight leg raise on the right with hypesthesia noted in the sole of the left foot. The patient underwent therapy as well. However, his symptoms did not resolve and he was complaining subsequently of pain into both sides of the lower extremities with paresthesias. He was also treated with medications of Medrol Dosepak and Darvocet N-100.

A subsequent MRI on August 17, 2009, of the lumbar spine showed high-grade canal stenosis at L3-L4 and L4-L5 with 70-80% narrowing. There was lesser involvement at L2-L3 but there was neuroforaminal narrowing at L5-S1.

The patient did have lumbar epidural steroid injections performed by Dr., although I did not have specific notes from Dr. for review. These provided what appeared to be minimal long-term benefit. Surgical referral for neurosurgical consultation was done. This assessment was apparently done by Dr. per Dr. designated doctor report although we do not have the specific records from Dr.. However, per Dr. report, the L3-S1 levels were proposed for decompression.

Per Dr. office note, Dr. discontinued seeing workers compensation. Thus a different surgeon would be needed.

There was also an assessment by Dr. (M.D.) for electromyography and nerve conduction study. This was interpreted by Dr. to show a left S1 radiculopathy.

On April 27, 2010, Dr., occupational medicine/family practice, evaluated Mr. for maximum medical improvement and determined the patient was not at maximum medical improvement. On the examination performed by Dr. there was noted to be a grossly antalgic gait, kyphotic lumbar angulation, and no Waddell signs of significance. He also noted that the patient had neurogenic claudication with ambulation.

Dr. proposed that the patient was not at maximum medical improvement and that surgical decompression would be indicated.

On September 27, 2010, Dr. (M.D.) at noted Dr. no longer accepted workers comp patients and referred the patient for another neurosurgical or orthopedic assessment. On November 3, 2010, Dr. (M.D.) evaluated the patient. Given the clinical and imaging studies, he proposed that the patient would be a candidate for L3, L4, and L5 laminectomy and decompression.

Subsequent URA determinations per with Dr. (M.D.) and Dr. (D.O.) denied the patient's medical necessity for the decompression surgery.

The denials are inconsistent with the patient's clinical presentation and imaging correlation. The designated doctor has also noted the patient's antalgic gait, kyphotic posture, lack of Waddell signs, and a neurogenic claudication. The request for surgical decompression is approved. Thus the decision by the URA is overturned. This opinion is based on ODG as well as my medical judgment, clinical experience and expertise, and accordance with the excepted medical standards and my fellowship training in spine surgery.

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**