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DATE OF REVIEW:

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Lam Right L4-5, possible L3-4 decompression

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

This case was reviewed by a Texas licensed MD, specializing in Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery
 TX DWC ADL

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Lumbar Lam Right L4-5, possible L3-4 decompression	63047, 63048	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
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4					

PATIENT CLINICAL HISTORY [SUMMARY]:

DOI: xx/xx/xx. The patient presented as a xx y/o male with h/o two previous lumbar surgeries. A lumbar MRI on 8-7-07 revealed previous laminectomy at L5-S1; multilevel degenerative disc bulging of a relatively mild degree; and no evidence of nerve root compression at any level. On the initial visit with Dr. on 8-9-07, he alleged LBP and radiating symptoms into the right leg to the dorsum of the foot; sensorimotor exam was normal, and reflex exam was symmetric. On the second visit with Dr. 8-30-07, he alleged weakness in the right leg: PE reflected a confusing statement regarding strength, and sensory and reflex exams were normal. On the third visit (9-20-07) the patient had worse back pain and continued to c/o right leg weakness;

sensorimotor exam was completely normal. On 9-25-07, Dr. performed a caudal L5-S1 ESI. On the fourth visit (10-11-07, Dr. states the ESI was fruitless, and states the patient was developing worse weakness; despite the subjective claims of worsening weakness, the sensorimotor exam remained unchanged (normal). On 11-8-07 Dr. states the patient had been hospitalized for a stroke. Only rest and "very large amounts[s]" of pain medication seem to help the patient, including hydrocodone 10/500 and Soma. This is the very first exam where there is documentation of any abnormality of the sensorimotor exam, stating a "suggestion" of "minimal" weakness in ankle dorsiflexors, and now symmetrically absent DTR; otherwise, sensation and strength were normal. Then on 11-21-07 Dr. reported that the patient "denies frank weakness," and now less than two weeks after the very first documentation of any type of motor weakness or DTR alteration, reported normal motor strength and DTRs, but a new-onset of right "L4-S1" sensory loss (coincident to the NDS performed that day, which suggested both acute and chronic radiculopathic changes in right L5-S1). On 11-29-07 Dr. discovers a recurrence of the bilateral DTR abnormality (only 8 days after documenting complete resolution of such), and documented complete resolution of any sensory deficit. Despite the continued subjective assertion of leg weakness, the motor exam remained completely normal. CT-myelogram on 11-30-07, interpreted by Dr., suggested mild broad based disc bulge and minimal NF narrowing at L3-4; moderated broad based disc bulge and NF narrowing at L4-5; and previous laminectomy and desiccated non-bulging disc with facet arthrosis at L5-S1. On 12-13-07, DTRs were now symmetrically hypoactive, and the sensorimotor exam remained completely normal. On 1-10-08 reflexes are again normal; sensorimotor exam remains normal. On the 1-11-08 initial visit with Dr. the patient now asserts bilateral leg symptoms (right > left), and asserts worsening symptoms (although the VAS 7-8/10 is less than the 9/10 previously reported). Dr. reports some improvement with the ESI, in contradistinction to Dr.. Dr. reported the patient was using a cane due to leg weakness; the patient was taking 6 hydrocodone 10/500 and four Soma per day; as well as anxiety and depression (for which he recommended psychiatric evaluation). Dr. recorded only minimal right EHL weakness; sensory and DTR exam was unremarkable. Dr. recommended surgery: decompression at L4-5 on the right, stating it would not help his back pain, but "may help some of" the leg symptoms.

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

Agree with previous two non-authorization determinations. There is consistently inconsistent documentation of sensory, motor, and reflex abnormalities over an extended period of time. The patient has never responded to conservative treatment or tincture of time, preferring rest rather than rehab, as well as large, steady quantities of narcotic and muscle relaxant medication. The patient has evidence of symptom magnification, reporting weakness and using a cane, despite inconsistent documentation of, if any, mild EHL weakness. The sensory exam was abnormal only on the very day that the NDS was performed. Neither the MRI nor the CT-myelogram demonstrated evidence of a neurocompressive lesion at any level. The patient responded minimally (or not at all, depending on which document one reads) to the ESI, which would be distinctly unusual in the circumstance of acute inflammation due to acute injury. Dr. recommended surgical decompression on the right at a L4-5, despite insufficient clinical evidence of radiculopathy, insufficient evidence of nerve root compression, a NDS that showed possible (likely chronic) radiculopathy at right L5-S1, for a patient with psychologic overlay (anxiety and depression), previous multiple back surgeries, symptom magnification (subjective worsening weakness and use of a cane), and resistance to rehab while steadily consuming large doses of narcotics and muscle relaxants. ODG criteria have not been met, particularly with regard to consistent clinical evidence of radiculopathy and imaging evidence of nerve root compression. From a psychological standpoint, this patient would appear to be a very poor surgical candidate. This patient has far exceeded evidence-based treatment and RTW guidelines.

ODG Indications for Surgery™ -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. ([Andersson, 2000](#)) Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

A. L3 nerve root compression, requiring ONE of the following:

1. Severe unilateral quadriceps weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps weakness
3. Unilateral hip/thigh/knee pain

B. L4 nerve root compression, requiring ONE of the following:

1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
3. Unilateral hip/thigh/knee/medial pain

C. L5 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
2. Mild-to-moderate foot/toe/dorsiflexor weakness
3. Unilateral hip/lateral thigh/knee pain

D. S1 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
3. Unilateral buttock/posterior thigh/calf pain

([EMGs](#) are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

A. Nerve root compression (L3, L4, L5, or S1)

B. Lateral disc rupture

C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

1. [MR](#) imaging
2. [CT](#) scanning
3. [Myelography](#)
4. [CT myelography](#) & X-Ray

III. Conservative Treatments, requiring ALL of the following:

A. Activity modification (not bed rest) after patient education (>= 2 months)

B. Drug therapy, requiring at least ONE of the following:

1. NSAID drug therapy
2. Other analgesic therapy
3. Muscle relaxants
4. Epidural Steroid Injection (ESI)

C. Support provider referral, requiring at least ONE of the following (in order of priority):

1. Physical therapy (teach home exercise/stretching)
2. Manual therapy (massage therapist or chiropractor)
3. Psychological screening that could affect surgical outcome
4. Back school (Fisher, 2004)

ODG Integrated Treatment/Disability Duration Guidelines

Low Back Problems

Note: The Treatment Planning sections outline the most common pathways to recovery, but there is no single approach that is right for every patient and these protocols do not mention every treatment that may be recommended. See the Procedure Summaries for complete lists of the various options that may be available, along with links to the medical evidence.

Identify Radicular Signs

- First visit: may be with Primary Care Physician MD/DO (50%), Orthopedist (33%), or Chiropractor (17%)
- Determine presence or absence of radiculopathy:
 - o Medical history
 - o Sensation: Feeling pain radiating below the knee (calf or lower), not just referred pain (pain radiating to buttocks or thighs), & dermatological sensory loss
 - o Straight leg raising test (sitting & supine), productive of leg pain
 - o Motor strength and deep tendon reflexes

- o Document flexibility/ROM (fingertip test), muscle atrophy (calf measurement), local areas of tenderness, visual pain analog, sensation alternation
 - o NOTE: Radiculopathy is often over-diagnosed. For unequivocal evidence of radiculopathy, refer to the *AMA Guides to the Evaluation of Permanent Impairment*, 5th Edition, page 382-383. ([Andersson, 2000](#))
- Rule out “red flag” diagnoses, including diagnostic studies, for specialist referral:
 - o Cauda Equina Syndrome [ICD9 [344.6](#)] (Schedule emergency procedure)
 - o Fracture, Compression fracture, Dislocation, Wound [ICD9 [733.13](#), [805.4](#), [805.5](#), [806.4](#), [806.5](#), [839.2](#), [838.3](#), [876](#), [911](#), [922.3](#), [926.11](#), [942](#), [952.2](#)]
 - o Cancer, Infection [ICD9 [171.7](#), [195.8](#), [215.7](#)]
 - o Dissecting/Ruptured Aortic Aneurysm [ICD9 [441.0](#)]
 - o Others (prostate problems, endometriosis/gynecological disorders, urinary tract infections, & renal pathology)
 - o Note: This guideline should not be used to suggest appropriate procedures for other conditions or comorbidities. When the treating doctor suspects any other diagnosis, they may decide what necessary testing should be performed, which may include laboratory tests such as erythrocyte sedimentation rate (ESR), complete blood count (CBC), and urinalysis (UA) to screen for nonspecific medical diseases (especially infection and tumor) of the low back.

Without Radiculopathy (90% of cases)

[ICD9 [724.2](#), [724.5](#), [724.8](#), [724.9](#), [846.0](#), [847.2](#), [847.9](#)]

- Also first visit (day 1):
 - o Prescribe [decreased activity](#), if necessary, based on severity and difficulty of job; limited passive therapy with [heat/ice](#) (3-4 times/day), [stretching/exercise](#) (training by physical therapist OK), appropriate [analgesia](#) (i.e., acetaminophen) and/or [anti-inflammatory](#) (i.e., ibuprofen) [*Benchmark cost*: \$14]; [back to work](#) except for severe cases in 72 hours, possibly [modified duty](#); AVOID [bed rest](#)
 - o REASSURE PATIENT: [Patient education](#) - common problem (90% of patients recover spontaneously in 4 weeks)
 - o No [X-Rays](#) unless significant trauma (e.g., a fall)
 - o If muscle spasms, then consider [muscle relaxant](#) with limited sedative side effects [*Benchmark cost*: \$44] (Note: The purpose of muscle relaxants is to facilitate return to activity, but muscle relaxants have not been shown to be more effective than NSAIDs.)

<p>ODG Return-To-Work Pathways (<i>847.2 lumbar sprain & 724.2 lumbago</i>)</p> <p>Modified Duty --</p> <p>Mild (Grade I)¹, clerical/modified work: 0 days</p>

<p>Severe (Grade II-III)¹, clerical/modified work: 3 days</p> <p>(See ODG Capabilities & Activity Modifications for Restricted Work under “Work” in Procedure Summary for Ergonomic accommodations)</p>
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- Second visit (day 3-10 – about 1 week after first visit, or sooner, because [delayed treatment](#) is not recommended)
 - o Document progress (flexibility, areas of tenderness, motor strength, straight leg raise – sitting & supine)
 - o If still 50% disabled (i.e., cannot return to work) then consider referral for exercise/instruction/manual therapy [*Benchmark cost: \$250*]: Options are [physical therapist](#), [chiropractor](#), [massage therapist](#), or [occupational therapist](#) (3 visits in first week), or by treating DO/MD. (Choose providers supporting active therapy and not just passive modalities. The focus of treatment should not be symptom reduction, but improving function with a goal of return to work.) Consider screening for [psychosocial symptoms](#) in cases with expectations of delayed recovery.
 - o Discontinue muscle relaxant

<p>ODG Return-To-Work Pathways (<i>847.2 lumbar sprain & 724.2 lumbago</i>)</p> <p>Manual Work --</p> <p>Mild, manual work: 7-10 days</p> <p>Severe, manual work: 14-17 days</p>
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- Third visit (day 10-17 – about 1 week after second visit)
 - o Document progress
 - o Prescribe muscle-conditioning [exercises](#)
 - o At this point 66%-75% should be back to regular work
- o While not indicated in the absence of red flags, if still disabled, then consider [imaging study](#) (AP/Lateral 2-view X-Ray of lumbar) [*Benchmark cost: \$150*] to rule out tumor, fracture, osteoporosis, myelopathy [ICD9 [721.3](#), [721.4](#), [724.02](#)]
 - o Maintain therapy, continue focus on active therapy and not passive modalities, 2 visits in next week, teach home exercises
 - o End manual therapy at 4 weeks (1 visit in last week)

<p>ODG Return-To-Work Pathways (<i>847.2 lumbar sprain & 724.2 lumbago</i>)</p> <p>Manual & Heavy Manual Work --</p> <p>Severe, manual work: 14-17 days</p> <p>Severe, heavy manual work: 35 days</p>

With Radiculopathy (10% of cases)

[ICD9 [722.1](#), [722.2](#), [722.32](#), [722.52](#), [722.73](#), [722.83](#), [722.93](#), [724.0](#), [724.3](#), [724.4](#)]

- Also first visit (day 1)
 - o Same as non-radicular

ODG Return-To-Work Pathways (<i>722.x intervertebral disc disorders</i>)
Disc bulge --
Mild cases with back pain, avoid strenuous activity: 0 days
Herniated disc --
Initial conservative medical treatment, clerical/modified work: 3 days

- Second visit (day 3-10 – about 1 week after first visit)
 - o Same as non-radicular, but
 - o Reassure, but if increased numbness or weakness of either leg, get back to provider in one day
 - o Consider referral to nonsurgical musculoskeletal physician (Orthopedist/Physical Med/Sports Med)
- Third visit (day 10-17 – about 1 week after second visit)
 - o Same as non-radicular, but
 - o About 50% can be back at modified duty
 - o If improvement, then add strengthening [exercises](#), increased activity
- Fourth visit (day 21 to 28 – about 1-2 weeks after third visit)
 - o Document objective findings, if no improvement then:
 - o First [MRI](#) (about 3% of total cases, or 30% of radicular cases) to confirm extruded disk with nerve root displacement (\geq 1 month [conservative](#) therapy) [*Benchmark cost: \$1,600*]
 - o (MRI or CT **not** indicated without obvious clinical level of nerve root dysfunction, clear radicular findings, or before 3-4 weeks)
 - o [EMG's](#) (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 4-8 weeks conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious

- o Consider an [ESI](#) (Epidural Steroid Injection) for severe cases hoping to avoid surgery [*Benchmark cost: \$676*] (Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, but this treatment alone offers no significant long-term functional benefit.)
- o If psychological factors retarding recovery are suspected, possibly refer to psychologist for testing [*Benchmark cost: \$540*]
- o Education: Consider [back school](#) as an option, if available
- o If no improvement 7-14 days after the first ESI, consider prescribing 2nd ESI [*Benchmark cost: \$615*]; there should be a maximum of two ESI's, and the second ESI can be 7-14 days after the first, depending upon the patient's response and functional gain.

<p>ODG Return-To-Work Pathways (<i>722.x intervertebral disc disorders</i>)</p> <p>Initial conservative medical treatment, manual work: 28 days</p> <p>Initial conservative medical treatment, regular work if cause of disability: 84 days</p>

- Surgery (three months or more – after appropriate work-up and consultation, concordance between radicular findings on radiologic evaluation and physical exam findings) (about 2% of total cases, or 20% of radicular cases) ([See also ODG Indications for Surgery™ -- Discectomy](#) in Procedure Summary.) Unequivocal objective findings are required based on neurological examination and testing.
 - o Refer to fellowship trained Spine Surgeon: Neurosurgeon (50%), Orthopedist (50%)
 - o Before surgery, screen for [psychological symptoms](#) that could affect surgical outcome (e.g., substance abuse, child abuse, work conflicts, somatization, verbalizations, attorney involvement, smoking)
 - o Review options/outcomes with patient, let patient be part of decision making
 - o Simple [discectomy/laminectomy](#), minimally invasive [*Benchmark cost: \$17,400*]
 - o Post-op pain, walking exercises, physical therapy

<p>ODG Return-To-Work Pathways (<i>722.x intervertebral disc disorders</i>)</p> <p>Discectomy, clerical/modified work: 28 days</p> <p>Discectomy, manual work: 56 days</p> <p>Discectomy, heavy manual work: 126 days to indefinite</p> <p>Laminectomy, clerical/modified work: 28 days</p> <p>Laminectomy, manual work: 70 days</p> <p>Laminectomy, heavy manual work: 105 days to indefinite</p>
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- o Failure to recover: See the [Procedure Summary](#) for options that may be available, along with links to the medical evidence. Also see the [Chronic Pain Chapter](#).

¹ **Definition of Sprain/Strain Severity Grade:** In general, a **Grade I** or mild sprain/strain is caused by overstretching or slight tearing of the ligament/muscle/tendon with no instability, and a person with a mild sprain usually experiences minimal pain, swelling, and little or no loss of functional ability. Although the injured muscle is tender and painful, it has normal strength. A **Grade II** sprain/strain is caused by incomplete tearing of the ligament/muscle/tendon and is characterized by bruising, moderate pain, and swelling, and a **Grade III** sprain/strain means complete tear or rupture of a ligament/muscle/tendon. A sprain is a stretch and/or tear of a ligament (a band of fibrous tissue that connects two or more bones at a joint). A strain is an injury to either a muscle or a tendon (fibrous cords of tissue that connect muscle to bone). ([Hannafin-NIH, 2004](#))

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

ODG:

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: the Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on .

