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Notice of Independent Review Decision

DATE OF REVIEW: 2/1/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Laminectomy @ Left L2-3, L3-4, L4-5 with 2-day inpatient hospital stay

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

Certified by the American Board of Orthopedic Surgery

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	722.10	63047	Upheld
		Prospective	722.10	63048	Upheld
		Prospective	722.10	99221	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Employer's first report of injury or illness dated 6/19/09

Physicians' records from 6/25/09 through 12/22/09

Physicians' letters dated 1/12/10, 9/24/09, 11/17/09

Notice dated 10/7/09

Operative report dated 9/23/09

Electromyography and Nerve Conduction Studies Report dated 10/29/09

X-ray reports dated 8/26/09

Official Disability Guidelines not provided

PATIENT CLINICAL HISTORY:

The patient is a female who is reported to have injured her low back as the result of a slip and fall occurring on xx/xx/xx. Records indicate that the patient was evaluated on 06/25/09. She is reported to have fallen on her backside. She went to the Emergency Room and CT scan was performed and was negative for fracture. She presents for evaluation of low back pain. She is a 1 pack per day smoker and on physical examination gait is observed to be normal. She is ambulatory without assistance. Examination of the back reveals no abnormalities. Lumbar range of motion is decreased. Straight leg raise is negative and muscle tone is normal. There is tenderness of the lower back bilaterally. Reflexes are 2+/4 with reinforcement. The patient was diagnosed with a lumbar sprain and lumbago and she was provided oral medications and was returned to work with restrictions. Serial clinical records indicate that the patient continued with follow ups and was referred for physical therapy. She had no significant improvement in her low back complaints. Her physical examination remains stable.

The patient was seen on 07/30/09. The patient is reported to have 9/10 low back pain with reduced lumbar range of motion. Physical examination shows provocative testing to be negative, straight leg raise is negative, DTRs are 2+. Motor strength is reported to be 5/5. She has tenderness over the sacral region. She subsequently underwent passive modalities.

On 08/10/09 the patient was seen in follow up. It is noted that the patient has started physical therapy but reports relief only 2-3 hours after treatment. Physical examination is unchanged.

Records indicate that on 08/26/09 the patient underwent radiographs of the lumbar spine which showed degenerative changes without fracture or dislocation. MRI of the lumbar spine was performed on this same date. This study reports mild bilateral hypertrophic facet changes at L1-2. At L2-3 there is a posterior broad based disc extrusion which extends approximately 4 mm in the central canal and in its central portion with an associated right protruding component ascending 6.2 mm into the central canal. There is also mild to moderate bilateral hypertrophic degenerative facet changes contributing to moderate bilateral subarticular recess narrowing. At L3-4 there is a broad based posterior disc bulge extending 3.3 mm into the central canal with an associated right subarticular extruding component extending 5.5 mm into the right subarticular recess and there are bilateral hypertrophic degenerative facet changes which contribute to moderate bilateral subarticular recess narrowing, right greater than left. At L4-5 there is a broad based posterior disc bulge extending 4.2 mm into the right subarticular recess with high signal change, most likely representing a radial tear. The left subarticular protruding component extends 2.4 mm into the left subarticular recess and there are bilateral hypertrophic degenerative facet changes at this level contributing to moderate bilateral subarticular recess narrowing. At L5-S1 there is no significant disc bulge or herniation and there are bilateral hypertrophic degenerative facet changes present contributing to mild bilateral subarticular recess narrowing. There is relative central canal narrowing at L2-3, L3-4 and L4-5 due to a combination of disc hypertrophic degenerative facet changes and hypertrophy of the ligamentum flavum.

The patient was seen in follow up on 08/31/09. At this time there is no reported improvement in her condition. On physical examination the patient is now reported to have pain radiating to the left posterior thigh with straight leg raise. The patient is subsequently recommended to undergo ESIs.

The patient was seen on 09/08/09. On physical examination the patient is reported to be well developed and well nourished. She has normal gait, normal station, normal heel / toe walk. She

has slightly antalgic gait favoring mostly the left lower extremity. Deep tendon reflexes are normal. Sensory is diminished in left L5 dermatomal pattern. There is some reported mild EHL weakness in left when compared to right. There is decreased range of motion of lumbar spine. There is marked tenderness over lumbar spine with increased muscle tone. The patient is opined to have left L5 radiculopathy and was recommended to undergo lumbar epidural steroid injection. Records indicate the patient underwent lumbar epidural steroid injection on 09/23/09.

An evaluation of 09/24/09 noted that the treatment appears to have been reasonable and related; however, it was noted that ODG would not support conclusion of radiculopathy in performance of lumbar epidural steroid injections given the patient's physical examination.

The patient was seen in follow-up on 10/08/09. At this time it is reported that the patient has improved with epidural steroid injection. Her leg is reported to have gotten remarkably better. She reports no pain down the leg. She has no giving way. Her pain is now focused in mid back. She subsequently is recommended to undergo additional epidural steroid injection.

On 10/29/09 the patient was referred for EMG/NCV study of lower extremities. This study reports left L5 and bilateral S1 radiculopathy. The patient was reported to have not made any significant improvement. Her physical examination stayed grossly unchanged.

The patient was evaluated by on 12/02/09. It is reported the patient developed significant pain radiating down left lower extremity and into foot after fall. She reports her left leg has been giving out on her ever since. She has undergone MRI and has diagnosis of disc herniation. She has had EMG/NCV and injections which have not helped. She has had physical therapy without improvement. She reports her pain is approximately 30% back and 70% left hip. On physical examination the patient is 5'9" tall and weighs 170 lbs. She is grossly hypertensive. She has slightly antalgic gait on left. She has some paravertebral muscle tightness on left with pain in sciatic notch. She has moderate restrictions to range of motion. She is reported to have 2 cm of atrophy in left calf. Motor strength is reported to be 4/5 in left EHL. Sensation is intact. Reflexes are symmetric. Straight leg raise is negative. Left L2-3, L3-4 and L4-5 laminectomy and possible partial discectomy was recommended.

The Reviewer noted the letter dated 1/12/10 which stated that the patient had no preexisting history of any back problems. She is reported to have fallen at work and subsequently developed left lower extremity pain. She has undergone MRI, EMG/NCV. In the letter, it was opined that the patient has persistent radicular symptoms evidence of radiculopathy, which corresponds to both EMG/NCV and MRI. It was reported she has failed conservative treatment to include time, activity modification, physical therapy and injections. L2-3 through L4-5 laminectomy decompression with possible discectomy was again recommended.

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

In the Reviewer's opinion, the request for lumbar laminectomy on left at L2-3, L3-4 and L4-5 with 2 day inpatient stay is not supported by the submitted clinical information. The submitted clinical information indicates the patient slipped and fell on her buttocks on 06/19/09. The patient presented with complaints of bilateral lower back pain. Her initial physical examination was unremarkable. The patient underwent extensive conservative treatment without sustained improvement. Serial physical examinations of the patient are not wholly consistent. It is noted that the patient reported improvement with an ESI. MRI dated 08/26/09 indicates multi level

degenerative changes involving L2-3, L3-4 and L4-5 with no significant findings at L5-S1. The patient has undergone EMG/NCV study which reports a left L5 and bilateral S1 radiculopathy which does not correlate with her physical examination or imaging studies. Given the lack of correlation between the patient's subjective complaints, electrodiagnostic studies and imaging studies, the requested procedure would not be medically necessary. It is noted that imaging studies do not indicate any significant pathology at the L5-S1 segment yet electrodiagnostic studies report left L5 and bilateral S1 radiculopathies. The patient does not present with physical examination findings which would support the presence of left sided radiculopathy involving L2-3 or L3-4. Given the lack of correlation between the data, operative intervention would not be medically necessary.

Reference:

The 2010 Official Disability Guidelines, 15th edition, The Work Loss Data Institute. Online edition.

Discectomy/ laminectomy

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 (chiropractor or massage therapist)
 3. Psychological screening that could affect surgical outcome
 4. Back school (Fisher, 2004)

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)