

INDEPENDENT REVIEWERS OF TEXAS, INC.

4100 West El Dorado Pkwy · Suite 100 – 373 · McKinney, Texas 75070

Office 469-218-1010 · Toll Free 1-877-861-1442 · Fax 469-218-1030

e-mail: independentreviewers@hotmail.com

Notice of Independent Review Decision

DATE OF REVIEW: 04/14/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Inpatient right lumbar foraminotomies L2-3, L3-4

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

Texas Board Certified Neurosurgeon

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Operative report L4-L5 discectomy, bilateral carpal tunnel release, 04/30/02
2. History and physical, 04/30/02
3. Operative report redo laminectomy L4-L5 and laminectomy L5-S1, posterolateral fusion, posterior lumbar interbody fusion L4-L5, L5-S1, 04/22/03
4. Office visit notes, , M.D., 06/18/03 thru 11/16/09
5. History and physical, 09/08/03
6. Discharge summary, 09/11/03
7. Office visit note, , M.D., 09/22/03
8. New patient history and physical, , M.D., 10/09/03
9. MRI lumbar spine, 10/06/08
10. Nerve conduction study and EMG report addendum note, 12/16/08
11. Lumbar spine CT/myelogram, 03/16/09
12. New patient history and physical/neurosurgical consultation, , M.D., 06/10/09
13. Utilization review decision, D.O., 01/22/10
14. Utilization review appeal decision, , M.D., 02/23/10
15. ***Official Disability Guidelines*** Low Back Chapter

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female whose date of injury was xx/xx/xx.

The employee has undergone multiple surgical procedures including L4-L5 discectomy as well as bilateral carpal tunnel release performed 04/30/02, with posterolateral/

posterior lumbar interbody fusion L4-L5, L5-S1 04/22/03. The employee reportedly did reasonably well following surgery but continued to have quite a bit of low back pain and right leg pain.

The employee was seen for neurosurgical evaluation on 06/10/09 by Dr. xxxxx. Physical examination at that time reported the employee to be 5'6" tall and 205 pounds. A well healed lumbar surgical scar was noted. There was some pain to palpation across the lower lumbar spine. Cranial nerves II-XII were intact. Motor testing reported 5/5 motor strength in the left lower extremity. There was weakness in right lower extremity with quadriceps extension, dorsi and plantar flexion of right foot and ankle 4/5. Sensory examination was essentially intact on left side with decreased sensation in right distal leg and foot and diffuse nondermatomal distribution. Reflexes were 1 at bilateral knees and ankles, equal and symmetric. Gait testing reported slow, antalgic with right sided limp. Straight leg raise reproduces pain on right side. The employee was noted to have limited range of motion of lumbar spine secondary to pain.

MRI of the lumbar spine dated 10/06/08 revealed postsurgical changes on right at L3-L4, L4-L5, and L5-S1. Facet arthropathy was seen at lower lumbar levels with neural foraminal narrowing on right at L5-S1. Canal stenosis is seen at L2-L3 and L3-L4.

A CT myelogram dated 03/16/09 revealed lumbosacral degenerative disc disease and facet arthropathy. Postsurgical changes were reported from L4-S1. Dr. noted the employee was not interested in conservative treatment and recommended the employee undergo foraminotomies at L2-L3 and L3-L4 on right.

A utilization review by, D.O., performed on 01/22/10 determined the request for inpatient right lumbar foraminotomies L2-L3, L3-L4 was not indicated as medically necessary. Dr. noted that the employee reportedly had been treated conservatively with oral medications, but there was no documentation of conservative treatment including therapy progress notes indicating non-improvement. Dr. noted maximum potential conservative treatment was not fully exhausted prior to pursuing surgical intervention.

On 02/23/10<, M.D., reviewed an appeal request and determined medical necessity was not established. Dr. noted the employee had undergone a previous fusion L4-S1 and was now experiencing significant degenerative symptoms from canal stenosis above fusion level. Dr. noted the submitted clinical documentation did not provide evidence of failed conservative treatment with no indication of recent therapy or medical management submitted for review. Therefore, medical necessity could not be established.

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

The clinical data presented for review does not support determination of medical necessity for proposed inpatient right lumbar foraminotomies L2-L3, L3-L4. The employee has a history of previous lumbar surgery to include posterior lumbar interbody fusion at L4-L5 and L5-S1. The employee was noted to have complaints of low back pain and right leg pain. Imaging studies revealed multilevel degenerative disc disease of lumbar spine with disc bulging and facet arthropathy at L2-L3 and L3-L4 with moderate central stenosis without foraminal stenosis. Postsurgical changes were noted

at L4-L5 and L5-S1. Records indicate the employee had conservative treatment prior to previous surgical intervention, but there is no documentation of recent conservative treatment other than medications. **Official Disability Guidelines** indicate that conservative treatment should be attempted prior to proceeding with surgery including activity modification, drug therapy, epidural steroid injections, and physical therapy. Noting the lack of documentation of conservative treatment, medical necessity was not established. The previous denials should be upheld on IRO.

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

2010 **Official Disability Guidelines**, 15th Edition, The Work Loss Data Institute. Online edition. Low Back Chapter

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](#))