

Notice of Independent Review Decision

**DATE OF REVIEW:** 12/30/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Right L5-S1 Microlumbar discectomy

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

The physician performing this review is Board Certified, American Board of Orthopaedic Surgery. He was certified, 1998-2001, by his domiciled state with a Workers's Compensation Certification in Impairment Rating Evaluations. He has been in private practice since 1986. He has been previously appointed to the National Association of Disability Evaluating Professionals. This physician is a member of his local, state and national medical associations.

**REVIEW OUTCOME**

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

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

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The requested right L5-S1 microlumbar discectomy is not medically necessary based on review of the medical record provided.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

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Records Received: 19 page fax on 12/20/2010 Texas Department of Insurance IRO request and 18 page fax on 12/24/2010 URA response to disputed services including administrative and medical records.

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant reported the occurrence of low back pain on x/xx/xx when climbing a pole; he then was doing some training exercises a week later, picking up a person in a bucket, and had worsening of the pain. He is diagnosed with an L5-S1 disc herniation with radiculopathy. He was initially evaluated and treated by Dr. and was seen on two occasions (9/13/10 and 9/20/10). He reported pain in the right gluteal region radiating down his right leg and it was noted that he had a prior surgical history of lower discectomy. He reported an occasional feeling of some tingling in the right lower extremity. Ibuprofen reportedly gave minimal relief. On examination there was a positive right straight leg raise test. An x-ray was reported to be negative for any evidence of an obvious compression fracture or subluxation. He was treated with an intramuscular injection of 80 milligrams of Depo-Medrol and was started on Robaxin. He continued with complaints of low back pain with radiation to the right leg and occasionally to the left when he was seen on 9/20/10; on examination there were no focal neurologic deficits and an MRI with and without contrast was ordered.

The 9/27/10 report of the lumbar spine MRI revealed that the claimant had a history of prior back surgery; there was a small protrusion right posterolaterally at L5-S1 with narrowing of the intervertebral foramina on the right side and compression of the right L5 and S1 nerve roots; a prominent disc bulge with narrowing of the intervertebral foramina bilaterally with nerve root compression especially on the left side and flattening of the dorsal root ganglion combined with short pedicles and severe facet arthropathy at L4-5; epidural enhancement was seen in the surgical bed at L4 and L5; narrowing was seen on the right at L3-4; and there was notation of severe facet arthropathy throughout the lumbar spine.

Dr. initially evaluated the claimant on 10/20/10. Subjective complaints were of pain going from the low back through the right buttock and hip down the posterior thigh and into the right leg, and occasional numbness of the right foot and occasional pain in the left buttock. Dr. indicated that the claimant had some injections which failed to give him sustained relief. On examination there was tenderness to palpation at the lumbosacral junction, the bilateral lower extremities were with normal sensation, hip and knee motion were functional, there was a strongly positive straight leg raise sign on the right at 45 degrees, a positive cross straight leg raise on the left, strength graded at 5 out of 5 in the bilateral lower extremities, gait was normal, and there were no objective sensory deficits. Dr. reviewed the MRI online and indicated that it showed a right sided

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disc herniation at L5-S1 with compression of the right L5 and S1 nerve roots, and that there was some significant facet arthropathy throughout the lumbar spine. The impression was of a right L5-S1 disc herniation with radiculopathy. It was felt that he was a good candidate for microlumbar discectomy, with notation that he had failed to improve with some injections and that there was significant nerve root compression on MRI.

A chart entry dated 11/15/10, authored by PA-C for Dr., indicated that the claimant had contacted the office on several different occasions over the past week complaining of increased pain down the right leg and numbness on the lateral aspect of the right foot. It was noted that he had been instructed on strengthening and stretching which he had been doing and that he had experienced worsening of his symptoms. The plan was to try and expedite the recommendation for surgery.

Two peer reviews were done; one was dated 11/16/10 and the second was dated 11/30/10. The former review was done by a neurosurgeon and it was determined that the requested right L5-S1 microlumbar discectomy was not medically necessary as there was no documentation of associated clinical findings such as loss of relevant reflexes, muscle weakness/atrophy of appropriate muscle groups, loss of sensation in a corresponding dermatome, and at least one support provider referral. The latter review was done by an orthopedic surgeon and it was determined again that the requested right L5-S1 microlumbar discectomy was not medically necessary with notation that there was no indication of conservative management or that the claimant had maximized the effect of oral medications, the clinical did not provide objective documentation of the clinical and functional response from the mentioned injection, and there was no indication that psychological evaluation had been done. The case had been discussed with the provider and it was noted that the claimant had not exhausted lower levels of care, and that Dr. had reviewed the chart and realized he did not have documentation that an ESI was done; Dr. apparently planned to set that up and then proceed with surgery request if still indicated.

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

The requested right L5-S1 microlumbar discectomy is not medically necessary based on review of the medical record.

This is a gentleman who has had ongoing back and radicular right leg complaints since an injury xx/xx/xx. There are medical records from Dr. documenting back

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and right leg complaints, although these do not document neurologic deficit but there is a positive straight leg raise. The office visit of Dr. documents a previous history of a lumbar discectomy. There is a September 27, 2010 MRI of the lumbar spine with and without contrast report that describes a right L5-S1 disc protrusion and compression of the right L5 and S1 nerve roots as well as significant L4-L5 changes and some epidural enhancement. There are then records from Dr. October 20, 2010 documenting the patient's complaints and findings with a positive straight leg raise yet no evidence of a neurologic deficit. There is then a November 15, 2010 telephone conversation from the office of Dr. describing the patient complaining of right leg numbness by telephone. This medical record does not document clear evidence of neurologic deficit such as numbness, weakness or loss of reflex. This medical record doesn't document that Dr. was aware of the fact that the patient had a previous lumbar operation. There is also no documentation that this patient has received aggressive conservative care to include physical therapy or epidural steroid injection.

ODG guidelines document the use of lumbar disc surgery in patients who have a disc herniation, ongoing subjective complaints, positive physical findings and failure of appropriate conservative care. In this case, the patient does not have neurologic deficit and does not appear to have failed aggressive conservative care since there does not appear to be documentation of an injection or therapy.

Therefore, the requested surgical intervention is not medically necessary.

## **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 KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

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- 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)

Official Disability Guidelines Treatment in Worker's Comp, 15<sup>th</sup> edition, 2010 Updates

Low Back

### **ODG Indications for Surgery**<sup>TM</sup> -- 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:

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:

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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.)

III. Conservative Treatments, requiring ALL of the following:

A. Activity modification (not bed rest) after patient education ( $\geq$  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)