Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC DAT

CLAIMS EVAL

Utilization Review and Peer Review Services

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

63030 Lumbar laminectomy/microdiscectomy @ left L5-S1 69990 Microsurgery Add-On 22851
Application Lumbar Spinal Prosthetic Device 99221 Hospital 23 hour observation

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

American Board of Orthopaedic Surgery-Board Certified

REVIEW OUTCOME

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

☒ Upheld (Agre
☐ e) Overturned (Disa
☐ gree)
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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

Medical records reflect the claimant sought medical attention at Clinic on 7-3-08. The claimant reported that he was moving objects and injured his back in the process he reports he has back pain without radiation to the buttocks or the lower extremities. On exam, he has decreased range of motion of the lumbar spine, mild tenderness at lumbar paraspinals. Motor testing is 5/5, SLR is negative. DTR are 2+. Plan: Prescription for Ibuprofen, physical therapy. The claimant was returned to work with restrictions.

Medical records reflect the claimant continued to follow up at Clinic. He continued conservative treatment with medications and physical therapy.

Physical therapy provided on 7-3-08, 7-7-08, 7-9-08, and 7-11-08.

8-12-08 MRI of the lumbar spine shows mild disc desiccation with left paracentral and left lateral 3mm to 4mm disc herniation at L5-S1 creating compression on the left side of the thecal sac and encroachment on the left S1 nerve root. Mild degenerative disc disease with left paracentral 3mm protrusion at L4-5 with mild facet arthropathy creates encroachment on the left side of the thecal sac and left L5 nerve root.

10-3-08 MD., the claimant Is a XX-year-old gentleman who initially injured himself back on XX/XX/XXXX when he was lifting an approximate 90-pound object at the employer's place of

business. He said that he "accidentally bent his back the wrong way." He has been on multiple medications over the past several months but cannot recall any of them except for ibuprofen 800 mg. He did go to physical therapy for 2 weeks for a total of 4 sessions but says it does not benefit him. He experiences some lower extremity radiculopathy down his right lower extremity with numbness and tingling in his great toe and second toe on the right side over the past 2 weeks. He feels as though his back is "stiff' which is his major complaint. His pain can vary anywhere from 3 out of 10 to 7 out of 10. The pain is worse in the morning. On exam, He was able to toe walk and heel walk across the clinic floor. Range of motion was mildly decreased, especially with extension, which exacerbated his back pain. Motor strength was 5 out of 5 except for some decreased strength in his right gastrocnemius muscle 5- out of 5. Light touch is Intact from L4-S1. Long track signs are negative. Plan: The patient is a xx-year-old gentleman with disk desiccation at L4-L5 and L5-S1 with associated disk herniations. He would like to evaluate this further with an EMG. Also place him on electrical stimulation for his back pain. He will start him on Naprosyn 375 mg as well as Soma. He will reevaluate after his EMG is obtained.

10-31-08 Unknown provider - The patient returns today for follow-up in regards to his low back pain and right lower extremity radiculopathy. He reports today that his pain is basically the same. Rates his pain at 7/10 which is worse in the mornings. He has undergone 2 weeks of physical therapy. He is currently on Naprosyn and Soma. Apparently his EMG was denied. His MRI does show left paracentral disk herniations at L4-L5 and L5-S1 along with mild disk desiccation at L5-S1. On exam, he has decreased strength in his left gastrocnemius muscle at 5-/5. Light touch remains intact from L4-S1. Long track signs are negative. He also has weakness in his left EHL at 4+/5. Plan: Forty-one-year-old gentleman with disk desiccation at L5-S1 and disk herniations at L4-L5 and L5-S1. His EMG was denied. He was started on a Medrol Dosepak, and he will reevaluate him in 2 weeks.

11-14-08 MD., The claimant's EMG was denied. He was started on Medrol and this gave him some relief. The evaluator will resubmit for another EMG.

12-18-08 MD., the claimant continues with right lower extremity radiculopathy. The evaluator recommended a right epidural steroid injection via transforaminal route at L4-L5 and L5-S1.

2-4-09 L4-L5 and L5-S1 right transforaminal epidural steroid injection.

2-12-09 MD., the claimant is seen for followup with regard to his preoperative right lower extremity radiculopathy. He underwent a set of epidural steroid injections performed on 2/4/2008. He is at least 50% better. He has been doing quite well today. He is very pleased with his progress. On exam, there is some mild weakness but increasing in the foot, 5-/5 EHL, gastrocnemius muscle. Straight leg raise testing is negative today on the right side. Plan: a XX-year-old gentleman with disk herniations at the L4-L5 and L5-S1. He had good response with the epidural steroid injections. At this time, he will start him on post injection physical therapy.

Physical therapy on 3-11-09, 3-17-09, 3-18-09.

3-19-09 MD., the claimant is status post epidural steroid injection performed on 02/04/08, This provided 70 to 80% relief for about 6 weeks. Patient states pain with radiation to lower extremities; however, of reduced intensity. Patient advised to undergo a second lumbar epidural steroid injection with excess fluid approach on the right to L4-L5 and L5-S1 since the patient has documented radiculopathy. He had overall 70 to 80% relief with the injection, which lasted for about 6 weeks. He strongly recommend repeating the injection for therapeutic reasons and/or simply just take effect.

On 5-6-09, the claimant underwent a right and left L4-L5 and L5-S1 transforaminal epidural steroid injection.

5-14-09 MD., the claimant presents today for followup visit for management of low back pain. He states his back feels better since his last visit. He is currently on Darvocet and Soma. The patient denies any pain of the lower extremity; however, complains of tingling in the left arm intermittently. The patient had injection performed to the umber spine, and he states to be

feeling 60% to 70% better with the second injection. He is satisfied with the results. The patient documents pain level of intensity 3-4/10, with 0 being in no pain, and 10 being in maximum pain. Patient, however, denies radiation to the lower extremities. He denies bowel or bladder incontinence. He denies any other constitutional symptoms. On exam, there is tenderness on palpation on the paraspinal region with intermittent soreness. Patient is able to perform heel-to-toe walk and squat and rise, however, with pain. Patient has mild weakness located on the foot 5-/5, right extensor hallucis longus and gastrocnemius. Straight leg raise test is negative on right lower extremity. Deep tendon reflexes 2/4 at bilateral L4 and S1. Babinski's is negative. Plan: Patient had significant relief with series of 2 injections of the lumbar spine. At this point in time, we recommend the patient to start post injection physical therapy for approximately 6 visits for synergistic effect, with an improved range of motion and improved muscle strength for him to return to work without any restriction. Patient to avoid stress with the lumbar spine. He was provided refill in all the pain medication that he has been taking in the past. All questions answered. He will evaluate this patient after the physical therapy session.

Physical therapy 5-21-09, 6-22-09, 6-24-09.

6-18-09 MD., the claimant presents today for a followup visit for management of low back pain. Patient had two injections performed to the lumbar spine, and he states approximately 60 to 70% better. Patient had 6 visits of physical therapy post injection approved. However, he could not have the physical therapy done since his mother passed away and he had to be in another state for about 3 weeks. Patient documents pain of intensity 5/10 on VA scale with 0 being no pain and 10 maximum pain. He states the back is still sore on prolonged sitting and prolonged walking. Patient is taking Soma as directed, but he could use some more new pain medication. Patient denies bowel or bladder incontinence. Denies any other constitutional symptoms. On exam, the claimant has no tenderness in the costovertebral angle. There is tenderness in palpation of the paraspinal region with intermittent soreness. Patient is able to perform heel-toe walk, squat and rise without any pain. Patient has weakness 5-/5 at extensor hallucis longus and gastrocnemius. Straight leg raise test is negative. Deep tendon reflexes are 2/4 in bilateral L4 and S1. Diagnosis: resolved lower extremity radiculopathy, lumbar nucleus pulposus, L4-L5 and L5-S1. Plan: Patient is provided a fresh prescription of post injection physical therapy to be approved since the previous approved physical therapy could not be performed. Patient is to continue oral pain medication as prescribed. We shall evaluate this patient in approximately 3 weeks' time after he completes physical therapy for further recommendations.

7-17-09 MD., the claimant is a XX-year-old, XX-American male who presents to the office today with a history of a job-related accident occurring on or about XX/XX/XXXX. The patient reports that while during the course and scope of employment with company, the patient was employed as an employee. The patient reports that he was performing his usual job duties, working in a specified capacity. He was picking up a 75-pound object. Apparently there was ice on the ground. He lost his footing, slipped on the ice and fell backwards. As a result, he sustained a low-back injury. The patient reported his injuries to his employer and initially sought treatment at the Provider, where he was evaluated. X-rays were taken. He was given oral medications and began a course of physical therapy. The patient eventually was sent for an MRI of his lumbosacral spine, which was apparently abnormal. However, it is not available today for review. The patient was then referred to Dr., who recommended spinal injections. He apparently underwent 2 spinal injections, followed by post-injection therapy. The patient was also recommended for electrodiagnostic studies which were apparently denied by the carrier. The patient reports that he followed up again with Dr., who recommended surgical intervention; however, the patient does not wish to pursue surgical options at this time. The patient presents today for, initial consultation-evaluation. The patient is currently complaining of pain and discomfort of his low back with pain radiating into his left leg. The patient reports that prolonged standing and walking aggravate his pain. He complains of intermittent muscular spasms. He reports that he is currently not working at the present time. His current medications include

Soma and Motrin. The patient in general has no other specific complaints at the present time. On exam, Lumbosacral spine, mild to moderate tenderness to palpation. Slight tenseness of the paravertebral muscles noted. Painful range of motion and slightly decreased in all directions. The patient is able to perform toe-heel-walk, walking-on-heels, and walking-on-tiptoes with moderate difficulty. Straight leg raises are positive on the left. Patellar reflexes are present. Ankle reflexes are present. Neurosensory is grossly intact. The musculature is 5/5 in all groups tested. There is normal temperature and color of the lower extremities, and the balance of the lumbosacral spine exam is essentially unremarkable. Impression: Lumbar radiculitis, HNP of the lumbosacral spine by history. Plan: The patient today is advised to continue with his oral medications of which he has adequate supplies. The patient is recommended for an orthopedic consultation and is given a prescription for an orthopedic consult. He would like to obtain copies of his medical records to review before making additional treatment recommendations. He is given a DWC-73 form, off work x 2 weeks. The patient is to return to the clinic in 2 weeks for a followup evaluation. The patient is to call the office if he develops any problems in the interim time.

Follow up with Dr. on 8-3-09 notes the claimant is given a prescription for Darvocet, Ultram ER, Motrin and Skelaxin. The claimant is pending orthopedic consultation.

Follow up with Dr. on 9-11-09 notes the claimant continues with pain and discomfort in his low back radiating to the left leg. The claimant was given a prescription for Darvocet, Ultram ER, Motrin and Skelaxin.

Follow up with Dr. on 12-14-09, 1-8-10, 2-22-10, 3-31-10, 5-19-10, 6-21-10, and 7-23-10 notes the claimant is continued with medications.

6-7-10, MD., performed a Designated Doctor Evaluation to determine the extent of the compensable injury. The extent of injury includes lumbar myofascitis with discogenic disease and evidence of some radiculopathy, having decreased sensation on the left distribution of L4-L5 and L5-S1 , and some muscular weakness in the left lower extremity, including quadriceps weakness and mild atrophy with about 1 cm difference in circumference of the left mid-calf as opposed to the right.

Regarding extent of injury, in his opinion, the examinee has significant discogenic disease by MRI. The MRI is also somewhat suggestive in that the impressions are: Mild disc desiccation with left paracentral and left lateral 3-4 mm disc herniation L5-S1 with compression of the left side of the thecal sac and encroachment of the left sacroiliac nerve root. Mild degenerative disc disease with left paracentral 3 mm protrusion L4-L5 with mild facet arthropathy encroaching the left side of the thecal sac and left nerve root with clinical suggestions of left lower extremity radiculopathy, particularly with L4-L5 and L5-S1.

6-28-10 Work Capacity Evaluation shows the claimant is functioning at a Medium PDL. His job requires a Heavy PDL.

8-13-10, MD., the claimant presents to the office today for consultation of a job-related accident. The patient continues to complain of pain and discomfort of his low back with pain radiating into his left leg. He reports that prolonged standing and walking aggravate his pain. The patient complains of intermittent muscular spasms. The patient since last seen has undergone a functional capacity evaluation on 06/28/2010, at which time he was found to be performing at a medium PDL. However, his job requires a heavy PDL. Reviewed and discussed the recent functional capacity evaluation in detail with the patient. The patient is currently pending approval of a chronic pain program. He requests refills of his oral medications. The patient in general has no other specific complaints at the present time. On exam, lumbosacral spine, mild to moderate tenderness to palpation. Slight tenseness of the paravertebral muscles noted. Painful range of motion and slightly decreased in all directions. The patient is able to perform toe-heel-walk, walking-on-heels, and walking-on-tiptoes with moderate difficulty. Straight leg raises are positive on the left, negative on the right. Patellar reflexes are present. Ankle reflexes are present. Neurosensory is grossly intact. The musculature is 5/5 in all groups tested. . There is normal temperature and color of the lower extremities, and the balance of the

lumbosacral spine exam is essentially unremarkable. Impression: Lumbar radiculitis, herniated nucleus pulposus of the lumbosacral spine by history. Plan: Today the patient is given a prescription for oral medications to include Hydrocodone 5/500 mg tablets, 430, one tablet by mouth twice a day p.r.n. pain; Ultram ER 300 mg tablets, 430, one tablet by mouth daily; Cymbalta 30 mg, #60, one tablet by mouth twice a day; Motrin 800 mg tablets, #60, one tablet by mouth twice a day with food; and Skelaxin 800 mg, one tablet by mouth twice a day. The recent functional capacity evaluation is reviewed and discussed in detail with the patient. The patient is currently pending approval of a chronic pain program. He is given a DWC-73 Form, off work x one month. The patient is to return to the clinic in one month for a followup evaluation.

Follow up with Dr. on 9-20-10 notes the claimant is continued with medications.

9-23-10, MD., the claimant is a XX-year-old male was seen for orthopedic consultation on September 23, 2010, for injuries that occurred to his lumbar spine that resulted from a work injury on XX/XX/XXXX. The above patient states, while on the job, he was working, when he slipped on ice and fell between vehicles and a pallet fell on top of him, weighing approximately 70 pounds. At point of impact, the patient felt extreme pain in his low back area that radiated down his left lower extremity. He proceeded to Provider, where he was examined, evaluated, and released with medications. He was eventually sent out for an MRI of his lumbar spine. He was referred to Dr., an orthopedic surgeon, who recommended lumbar epidural steroid injections. The 1st lumbar ESI gave the patient approximately 3 weeks of relief. The 2nd lumbar epidural steroid injection gave him approximately 3 months of relief, but his pain soon returned. He is currently under the care of Dr., who is prescribing medication for the patient. On exam, He is clearly uncomfortable sitting in his chair and has difficulty getting up out of the chair and onto the examination table. His patellar reflexes are 2+ and symmetric bilaterally. His Achilles reflexes are blunted bilaterally. He has paresthesias in his left lower extremity, mostly in the lateral leg and foot. His motor strength is weakened in the extensor hallucis longus on the left as compared to the right. He has severe tenderness in his lower lumbar region. He has decreased range of motion with extension limited by pain. He has a positive straight leg raise on the left, negative on the right. His gait is unremarkable. He is able to heel-toe walk, walk on toes, and walk on heels with pain in his leg and low back area. Plan: obtain the patient's MRI films for further review. He will recommend Dr. obtaining a lower extremity EMG. The patient continues to complain of lower extremity symptoms, more so on the left side. He would need to obtain Dr. office reports as well as injection procedures. The patient was advised to continue his oral anti-inflammatory that was prescribed by Dr..

10-8-10, DO., performed a Doctor Selected by Treating Doctor Evaluation. He certified the claimant had reached statutory MMI on 10-1-10 and awarded the claimant 10% impairment rating.

12-6-10, MD., the claimant was provided with a prescription for Hydrocodone, Ultram ER, Cymbalta, Motrin, and Skelaxin. He is currently pending approval for EMG/NCS.

11-5-10, MD., the claimant returns on November 5, 2010, for followup on injuries to his lumbar spine that occurred on XX/XX/XXXX. Since patient's last visit, we recommended a preoperative lower extremity EMG, which is currently pending with his insurance carrier. Today, the patient presents with low back pain he rates as 7/10 with constant pain in his low back area that radiates down both lower extremities, more so on the left side. He continues to experience a burning sensation in his heels bilaterally. On examination of patient's lumbar spine, he continues to have severe tenderness in his lower lumbar region and decreased range of motion with flexion and extension limited by pain. He continues to have a positive straight leg raise on the left, negative on the right. His motor strength remains weakened in the extensor hallucis longus on the left as compared to his right. His reflexes in his Achilles are blunted bilaterally and his patellar reflexes are 2+ and symmetric. He continues to have paresthesias in his left lower extremity, mostly in his lateral leg and foot. He is unable to put pressure on his heels due to increased pain. Plan: Recommend Dr. obtaining a preoperative lower extremity EMG. We will see the patient back, once he has obtained his EMG, to review his results. The patient will

continue his oral anti-inflammatories as prescribed.

12-21-10 EMG/NCS of the lower extremities performed by, MD., showed mild sensory neuropathy involving the sural nerve. No electrodiagnostic evidence of left or right lumbosacral radiculopathy, peroneal or tibial neuropathy in the knee or ankle segments, polyneuropathy or sacral plexopathy.

1-14-11, MD., the claimant presents today for a work-related injury, which occurred on XX/XX/XX. The patient reports that while working during the normal course and scope of employment with company, he was employed as an employee. The patient states that on that particular day, he was working in a room. He was picking up a 75-pound object and apparently there was ice on the ground. He lost his footing, slipped on the ice and fell backwards. As a result, he sustained injuries to his low back. The patient reported his injuries to his employer and initially sought treatment at the Clinic where he was evaluated. X-rays were taken and was given oral medications and began a course of physical therapy. The patient was eventually sent for a lumbar which was apparently abnormal. The patient was then referred to Dr. who recommended spinal injections. The patient apparently underwent two spinal injections and followed by postinjection therapy. The patient was also recommended for EMG studies, which were apparently denied by the carrier. The patient was then followed up again by Dr. who recommended surgical intervention. However, the patient does not want to proceed with surgical options at that time. The patient then sought treatment with Dr. who examined the patient and recommended orthopedic consultation. The patient was referred to Dr., orthopedic surgeon who recommended lower extremity EMG test. The patient underwent lower extremity EMG test on December 21, 2010, which revealed, mild right sensory neuropathy in involving the, sural nerve. The patient reports that he has undergone three lumbar ESls. The patient has a followup appointment with Dr. on 01/19/11. The patient reports of ongoing low back pain. He states of pain, tingling and numbness referred to his left foot. Upon examination, the patient is noted to be a xx-year-old male. Examination of the :lumbar spine reveals tenderness of the lumbar paraspinals bilaterally. Lumbar ranges of motion are restricted. Straight leg raise test is positive bilaterally. There is decreased sensation of the left L5 dermatome. The reflexes of the lower extremity are within normal limits. Plan: Hydrocodone, Ultram and Skelaxin. The claimant is temporarily disabled.

3-4-11, MD., the claimant returns on March 4, 2011, for followup on injuries to his lumbar spine that occurred on XX/XX/XXXX. Since patient's last visit, he obtained a lower extremity EMG and is here to review those results. Today, the patient presents with back pain he rates as 5/10 with constant pain in his back area, discomfort with side-to-side movement, soreness, and stiffness. He has pain that radiates down his left lower extremity with numbness and tingling present, more so on the left side. He continues to experience a burning sensation in the heels bilaterally. On examination of the lumbar spine, he has severe tenderness in his mid to lower lumbar region and decreased range of motion with flexion and extension. He has a positive straight leg raise on the left, negative on the right. His motor strength remains weakened in his left extensor hallucis longus. His reflexes in his Achilles are blunted bilaterally. His patellar reflexes are 2+ and symmetric. He continues to have paresthesias in his left lower extremity, mostly in his lateral leg and foot. He is unable to put pressure on his heels due to increased pain. MRI film and report of patient's lumbar spine were available for review. They revealed a sizeable disk herniation at L4-L5 and L5-S1. A lower extremity EMG was performed on December 21, 2010; it revealed some mild sensory neuropathy involving the sural nerve. The rest of the examination was unremarkable. Impression: Neurogenic claudication with disk protrusion and herniation at L4-L5 and L5-S1, with left-sided radiculitis. Plan: At this time, he will recommend additional physical therapy. He will see the patient back in a few weeks to monitor his progress. His options were discussed regarding the lumbar surgery to help with his lower extremity symptoms. The patient will let us know when he is ready to proceed. The patient should continue his oral anti-inflammatories as prescribed

5-13-11, MD., the claimant returns on May 13, 2011, for followup on injuries to his lumbar spine that occurred on. Today the patient presents with low back pain he rates as
5/10 with constant pain in the back area, discomfort with side-to-side movement, soreness, and stiffness. He has pain that radiates down his left lower extremity with numbness and tingling present. The patient is here to discuss surgical intervention to his lumbar spine. He has been through an abundant course of physical therapy, oral anti-inflammatories, and he has had 2 lumbar epidural steroid injections. His first lumbar ESI gave him approximately 3 weeks of relief. His second ESI gave him 3 months of relief. The patient has been doing at-home physical therapy and increasing his mobility with little relief. He is interested in surgical intervention to help with his lower extremity symptoms. The patient had a medical evaluation performed on June 7, 2010, by Dr.. Dr. stated, "The extent of the injury includes lumbar myofasciitis with discogenic disease and evidence of some radiculopathy, having decreased sensation over the left distribution of L4-L5 and L5-S1 with muscular weakness in the left lower extremity including quadriceps weakness and mild atrophy about 1 cm difference in the circumference of the left mid calf as opposed to the right." The patient was treated by, MD, initially. Under his physical examination, the patient had positive straight leg raise on the left, negative on the right. He was diagnosed with lumbar radiculitis as well as herniated nucleus pulposus of the lumbosacral spine. The patient was referred to, MD, who evaluated the patient and performed 2 lumbar epidural steroid injections with temporary relief. The patient is here to discuss his surgical options regarding his lumbar spine to help with his left lower extremity symptoms. On exam, the patient is clearly uncomfortable sitting in the chair and has difficulty getting out of the chair and onto the examination table. He had severe tenderness in his mid to lower lumbar region with decreased range of motion to flexion and extension. Straight leg raises were positive on the left, negative on the right. His motor strength remained weakened in his left extensor hallucis longus as well as his quadriceps on the left as compared to the right. His Achilles reflexes were blunted bilaterally and barely elicitable. His patellae reflexes were 2+ and symmetric. He continued to experience paresthesias in his left lower extremity, mostly on his lateral leg and into his foot. He is unable to put pressure on his heel due to intense pain. MRI film and report of the patient's lumbar spine were available for review that revealed a sizeable disc herniation present at L5-S1 on the left. There was a central disc protrusion noted at L4-L5. Impression: Neurogenic claudication with disc protrusion herniation, L5-S1 with left-sided radiculitis. Plan: The patient continues to remain symptomatic. He has exhausted an abundant course of physical therapy, oral anti-inflammatories, and 2 lumbar epidural steroid injections with post-injection therapy with temporary relief. The patient's MRI reveals a disc herniation at L5-S1 on the left. This is consistent with his physical examination findings. After review of the patient's MRI, he will recommend a lumbar laminectomy and microdiscectomy at L5-S1 on the left. Procedure, risks, and benefits were discussed with the patient and informative handouts were given. He will proceed once authorized by his insurance carrier. The claimant will continue with his oral anti inflammatories.

5-26-11 UR performed by, MD., noted that on 05-24-2011 at 2:40pm CST, he talked to Dr,. He confirmed that the physical exam findings included weakness of the left big toe extensor and the left quadriceps. Both ankle reflexes were present but decreased. The MRI of 8-12-08 reveal a left 3-4 mm protrusion/herniation at L5-S1 on the left, and a 3 mm protrusion at L4-5 on the left. The following findings do not support the requested procedures: EMG 12-21-10 no findings of lower extremity radiculopathy. Dr. office notes of 7-17-09 reveal that the claimant can heel and toe walk, the ankle reflexes are present, strength is 5/5 and neurosensory is grossly intact. There is no mention of, or measurement of significant atrophy in Dr. notes. It has been nearly X years since the date of injury, and there is no clear, objective evidence of S1 radiculopathy. The guidelines would not support the proposed procedures, and they should not be approved.

6-7-11 UR performed by, MD., notes this patient was injured XX/XX/XXXX at company where he was employed; he slipped and fell. Over the ensuing years he saw several Drs., and.

Most of these doctors examined the patient for low back and left lower extremity pain and considered him to present with a radiculopathy. Epidural steroids were tried twice. Both times it produced temporary relief. Ultimately, the patient was seen by Dr., From September 2010 through his last visit May 13, 2011 the patient had continuing low back pain and left lower extremity complaints. Dr. described repeatedly positive straight leg raises and decreased sensation in an S1 nerve distribution. However, concomitant evaluation on December 21, 2010 by Dr. was unremarkable as were his performance of electrodiagnostic studies. Simply put, there was no confirmation of radiculopathy. A designated doctor examination on June 7, 2310 per Dr. concluded "some radiculopathy" and two levels on the left side. Demonstrably there was some left calf atrophy but only 1 cm on the left side. Flexion/extension x-rays were performed September 2010. They were unremarkable. The last and only MRI is very remote, dated to be August 12, 2008. At that time, it shows two-level degenerative changes the most of which was L5-S1 with some contact and S1 nerve impingement. Although the patient is now over two years with a clinical course with low back and left lower extremity pain, there is no documentation of true radiculopathy. The only imaging study he has had is remote, over two years prior, there is no confirmatory evidence by electrodiagnostic studies that in fact the patients back pain and left lower extremity pain is radiculopathic. He needs repeat imagine and further evaluation. The request of surgical intervention is neither warranted, necessary, or consistent with ODG at this time.

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

The claimant sustained a work related injury in XX/XXXX with a slip and fall. Initial medical evaluation noted complaints of back pain and right leg pain. The right leg pain persisted following diagnostic studies a lumbar MRI revealing degenerative disc changes cause L4-L5 and L5/S1 with left-sided protrusions.

Multiple physician evaluations have not revealed objective evidence of a neurological change in the lower extremities. There have been some reports of positive straight leg raising without specific descriptions as to whether this is just by pain or back and leg pain in the distribution of the specific nerve root.

EMG/NCV testing has revealed no neurological abnormality to correlate with the MRI of the lumbar spine.

The work event of XX/XXXX was not the producing cause of the lumbar spine MRI findings.

The request for 63030 Lumbar laminectomy/microdiscectomy @ left L5-S1; 69990 Microsurgery Add-On; 22851 Application Lumbar Spinal Prosthetic Device; 99221 Hospital 23 hour observation is not reasonable or medically indicated.

ODG-TWC, last update 6-17-11 Occupational Disorders of the Low Back – Laminectomy/Discectomy: Recommended for indications below. Surgical discectomy for carefully selected patients with radiculopathy due to lumbar disc prolapse provides faster relief from the acute attack than conservative management, although any positive or negative effects on the lifetime natural history of the underlying disc disease are still unclear. Unequivocal objective findings are required based on neurological examination and testing. (Gibson-Cochrane, 2000) (Malter, 1996) (Stevens, 1997) (Stevenson, 1995) (BlueCross BlueShield, 2002) (Buttermann, 2004) For unequivocal evidence of radiculopathy, see AMA Guides. (Andersson, 2000) Standard discectomy and microdiscectomy are of similar efficacy in treatment of herniated disc. (Bigos, 1999) While there is evidence in favor of discectomy for

prolonged symptoms of lumbar disc herniation, in patients with a shorter period of symptoms but no absolute indication for surgery, there are only modest short-term benefits, although discectomy seemed to be associated with a more rapid initial recovery, and discectomy was superior to conservative treatment when the herniation was at L4-L5. (Osterman, 2006) The SPORT studies concluded that both lumbar discectomy and nonoperative treatment resulted in substantial improvement after 2 years, but those who chose discectomy reported somewhat greater improvements than patients who elected nonoperative care. (Weinstein, 2006) (Weinstein2, 2006) A recent RCT compared decompressive surgery with nonoperative measures in the treatment of patients with lumbar spinal stenosis, and concluded that, although patients improved over the 2-year follow-up regardless of initial treatment, those undergoing decompressive surgery reported greater improvement regarding leg pain, back pain, and overall disability, but the relative benefit of initial surgical treatment diminished over time while still remaining somewhat favorable at 2 years. (Malmivaara, 2007) Patients undergoing lumbar discectomy are generally satisfied with the surgery, but only half are satified with preoperative patient information. (Ronnberg, 2007) If patients are pain free, there appears to be no contraindication to their returning to any type of work after lumbar discectomy. A regimen of stretching and strengthening the abdominal and back muscles is a crucial aspect of the recovery process. (Burnett, 2006) According to a major recent trial, early surgery (microdiscectomy) in patients with 6-12 weeks of severe sciatica caused by herniated disks is associated with better short-term outcomes, but at 1 year, disability outcomes of early surgery vs conservative treatment with eventual surgery if needed are similar. The median time to recovery was 4.0 weeks for early surgery and 12.1 weeks for prolonged conservative treatment. The authors concluded, "Patients whose pain is controlled in a manner that is acceptable to them may decide to postpone surgery in the hope that it will not be needed, without reducing their chances for complete recovery at 12 months. Although both strategies have similar outcomes after 1 year, early surgery remains a valid treatment option for well-informed patients." (Peul-NEJM, 2007) (Deyo-NEJM, 2007) A recent randomized controlled trial comparing decompression with decompression and instrumented fusion in patients with foraminal stenosis and single-level degenerative disease found that patients universally improved with surgery, and this improvement was maintained at 5 years. However, no obvious additional benefit was noted by combining decompression with an instrumented fusion. (Hallett, 2007) A recent British study found that lumbar discectomy improved patients' self-reported overall physical health more than other elective surgeries. (Guilfoyle, 2007) Microscopic sequestrectomy may be an alternative to standard microdiscectomy. In this RCT, both groups showed dramatic improvement. (Barth, 2008) There is consistent evidence that for patients with a herniated disk, discectomy is associated with better short-term outcomes than continued conservative management, although outcomes begin to look similar after 3 to 6 months. This is a decision to be made with the patients, discussing the likelihood that they are going to improve either way but will improve faster with surgery. Similar evidence supports the use of surgery for spinal stenosis, although the outcomes look better with surgery out to about 2 years. (Chou, 2008) Standard open discectomy is moderately cost-effective compared with nonsurgical treatment, a new Spine Patient Outcomes Research Trial (SPORT) study shows. The costs per quality-adjusted life-year gained with surgery compared with nonoperative treatment, including work-related productivity costs, ranges from $34,355 to $69,403, depending on the cost of surgery. It is wise and proper to wait before initiating surgery, but if the patient continues to experience pain and is missing work, then the higher-cost option such as surgery may be worthwhile. (Tosteson, 2008) Note: Surgical decompression of a lumbar nerve root or roots may include the following procedures: discectomy or microdiscectomy (partial removal of the disc) and laminectomy, hemilaminectomy, laminotomy, or foraminotomy (providing access by partial or total removal of various parts of vertebral bone). Discectomy is the surgical removal of herniated disc material

that presses on a nerve root or the spinal cord. A laminectomy is often involved to permit access to the intervertebral disc in a traditional discectomy.
Patient Selection: Microdiscectomy for symptomatic lumbar disc herniations in patients with a preponderance of leg pain who have failed nonoperative treatment demonstrated a high success rate based on validated outcome measures (80% decrease in VAS leg pain score of greater than 2 points), patient satisfaction (85%), and return to work (84%). Patients should be encouraged to return to their preinjury activities as soon as possible with no restrictions at 6 weeks. Overall, patients with sequestered lumbar disc herniations fared better than those with extruded herniations, although both groups consistently had better outcomes than patients with contained herniations. Patients with herniations at the L5-S1 level had significantly better outcomes than did those at the L4-L5 level. Lumbar disc herniation level and type should be considered in preoperative outcomes counseling. Smokers had a significantly lower return to work rate. In the carefully screened patient, lumbar microdiscectomy for symptomatic disc herniation results in an overall high success rate, patient satisfaction, and return to physically demanding activities. (Dewing, 2008) Workers' comp back surgery patients are at greater risk for poor lumbar discectomy outcomes than noncompensation patients. (DeBerard, 2008)
Spinal Stenosis: For patients with lumbar spinal stenosis, standard posterior decompressive laminectomy alone (without discectomy) offers a significant advantage over nonsurgical treatment. Discectomy should be reserved for those conditions of disc herniation causing radiculopahy. (See Indications below.) Laminectomy may be used for spinal stenosis secondary to degenerative processess exhibiting ligamental hypertrophy, facet hypertrophy, and disc protrusion, in addition to anatomical derrangements of the spinal column such as tumor, trauma, etc. (Weinstein, 2008) (Katz, 2008) A comparison of surgical and nonoperative outcomes between degenerative spondylolisthesis and spinal stenosis patients from the SPORT trial found that fusion was most appropriate for spondylolisthesis, with or without listhesis, and decompressive laminectomy alone most appropriate for spinal stenosis. (Pearson, 2010) See also Laminectomy.
Recent Research: Four-year results for the Dartmouth Spine Patient Outcomes Research Trial (SPORT, n= 1244) indicated that patients who underwent standard open discectomy for a lumbar disc herniation achieved significantly greater improvement than nonoperatively treated patients (using recommended treatments - active physical therapy, home exercise instruction, and NSAIDs) in all primary and secondary outcomes except work status (78.4% for the surgery group compared with 84.4%). Although patients receiving surgery did better generally, all patients in the study improved. Consequently, for patients who don't want an operation no matter how bad their pain is, this study suggests that they will improve and they will not have complications (e.g., paralysis) from nonoperative treatment, but those patients whose leg pain is severe and is limiting their function, who meet the ODG criteria for discectomy, can do better with surgery than without surgery, and the risks are extremely low. (Weinstein2, 2008) In most patients with low back pain, symptoms resolve without surgical intervention. (Madigan, 2009) This study showed that surgery for disc herniation was not as successful as total hip replacement but was comparable to total knee replacement in success. Pain was reduced to within 60% of normal levels, function improved to 65% normal, and quality of life was improved by about 50%. The study compared the gains in quality of life achieved by total hip replacement, total knee replacement, surgery for spinal stenosis, disc excision for lumbar disc herniation, and arthrodesis for chronic low back pain. (Hansson, 2008) For radiculopathy with herniated lumbar disc, there is good evidence that standard open discectomy and microdiscectomy are moderately superior to nonsurgical therapy for improvement in pain and function through 2 to 3 months, but patients on average experience improvement either with or without surgery, and benefits associated with surgery decrease with long-term follow-up. (Chou, 2009) According to a new study, surgery provides better results than non-surgical

treatment for most patients with back pain related to a herniated disk, but not for those receiving workers' compensation. (Atlas, 2010) Use of appropriateness criteria to guide treatment decisions for each clinical situation involving patients with low back pain and/or sciatica, with criteria based upon literature evidence, along with shared decision-making, was observed in one prospective study to improve outcomes in low back surgery. (Danon-Hersch, 2010)

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. 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)

For average hospital LOS after criteria are met, see Hospital length of stay (LOS).

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**
- ☐ **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)**