

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 24, 2011 **Amended Date:** April 28, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

63030 Low Back Disk Surgery
95920 Intraop nerve test

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

This physician is a Board Certified Neurosurgeon with over 40 years of experience.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On August 25, 2009 the claimant had an MRI of the Lumbar Spine without Contrast at Imaging. The MRI shows L5-S1 shows a 2.5-3mm broad based disc bulge which does not impinge the recesses or central canal. The central canal remains patent. The L5-S1 shows a 3.5mm broad based disc bulge. The central canal remains patent. There is mild narrowing of the bilateral neural foramen. Impression states L4-5 and L5-S1 discogenic degenerative change.

On November 19, 2009, M.D. performed a NCV/EMG on the claimant. Impression: A bilateral peroneal motor neuropathy at the fibular head is suggested (L>R). A (R) sural sensory neuropathy is noted. A (R) S-1 radiculitis is noted.

On January 14, 2010 the claimant was seen by MD. The neurological examination states Lumbar range of motion decreased in forward flexion secondary to body habitus and pain. The motor examination revealed a 5/5 strength throughout. Deep tendon reflexes were +2 throughout and symmetrical. Plantar responses were flexor bilaterally. Gait: The claimant had no difficulty with toe or heel walking. Tandem walk was within normal limits. The Straight Leg Raising was negative bilaterally. Spurling's sign was negative bilaterally. The sensory exam revealed a hypoaesthetic region in the L5 distribution on the right to pin prick and light touch, otherwise intact. Radiographic examination states Dr. reviewed the MRI of the lumbar spine dated August 25, 2009, which demonstrates a disc protrusion at L5-S1 centrally approximately 3mm and paracentrally and toward the left at L4-5 approximately 2 mm without significant central or bilateral foraminal stenosis. There was slight disc desiccation noted at both L4-5 and

L5-S1. There was no loss of disc height and lumbar alignment was within normal limits. The impression states: 1. Lumbar disc displacement; 2. Lumbar Radiculitis; 3. Lumbago; 4. Lumbar myofascial injury. Dr. recommended: 1. continuation of epidural steroid therapy; 2. chronic pain management therapy program if symptomatology does not abate. No prescriptions given. Dr. states "I do not feel this patient is a surgical candidate at this time."

On February 26, 2010 the claimant was seen by DO for a consultation. The physical examination states the claimant has moderate to severe lumbar paravertebral muscle spasm. There is decreased range of motion in the lumbar spine especially on flexion or extension, right and left side bending and hyperextension reproduces her back pain but not her radicular complaints. She has positive straight leg raising on the right leg from a seated position. Deep tendon reflexes are 1+ on the right and 3+ on the left. There is dramatic decrease in muscle strength in the right leg compared to the left especially on extension at the knee. The claimant walks with a cane because she has had the experience of having the right leg buckle on her. Her lumbar facets are tender to palpation. The radiographic studies reviewed are a lumbar MRI which shows at L4-5 a 3mm broad based disc bulge which does not impinge on the recesses or central canal. At L5-S1 there is a 3.5-4mm broad based disc bulge that narrows the neural foramen. There are early signs of degeneration in these two discs as well. Clinical findings from Dr. include: 1. Discogenic low back pain; 2. Lumbar radiculopathy related to #1; 3. bilateral lumbar facet syndrome. The recommendation states the claimant clearly would benefit from epidural steroid injections and she may well need lumbar facet, medial branch blocks.

On March 26, 2010 a lumbar epidural steroid injection procedure was performed by DO. Pre and post operative diagnosis was low back pain, lumbar radiculopathy.

On August 17, 2010 an MRI of the Lumbar Spine was done and interpreted by MD. The impression states: 1. A central and right paracentral L5-S1 disc extrusion is seen, this is close to both S1 nerve roots; 2. There is bulging at L4-S, a small tear of the annulus fibrosis is seen centrally at L4-5. The other levels studied appear unremarkable.

On October 25, 2010 claimant was seen by MD the examination states claimant weighs 260 pounds, there is tenderness over the spine, no deformity, no evidence of muscle spasm, there is limitation of motion in flexion and extension, straight leg raising elicits pain in the back of her knees, reflexes are active and symmetrical, there is no muscle weakness, the claimant did have intention and five way during the evaluation. Claimant states she has had sensory compromise involving most of her right leg without any specific dermatome distribution, Patrick test is negative bilaterally, vascular supply is intact, and claimant has a normal gait. Recommendation states Dr. feels the claimant has psychological overlay, evidence of disc herniation without specific neurologic compromise. Claimant would benefit from weight reduction prior to any surgical intervention.

On December 9, 2010 claimant was seen for a consultation by MD. The history portion of the consultation states that claimant uses a cane for ambulation and she had three episodes of incontinence about four months ago. The physical examination states the claimant walks without any assistive aids and has a severely antalgic gait favoring the right leg. On the right side she has severe weakness graded 4/5 in the anterior tibialis extensor hallucis longus, and gastrocnemius with complaint of paresthesia in the right L5 and right S1 distribution. Tension signs are positive reproducing back pain and right leg pain. Imaging states MRI is remarkable for herniated disc at L5-S1 level that is central and right-sided. The component could certainly be accounted for the claimant's radicular symptoms. Disc desiccation is noted at L4-5 and L5-

S1. Diagnosis: 1. L5-S1 disc herniation; 2. Lumbar radicular syndrome; 3. Internal disc derangement at L4-5 and L5-S1. Recommendation states that claimant is a candidate for a right sided L5-S1 discectomy.

On December 9, 2010 there is a radiology report that states AP flexion/extension radiographs showed no scoliosis, no spondylolisthesis, and no segmental instability. The report was interpreted by MD, MBA

On February 9, 2011 claimant was seen for a Behavioral Medicine Evaluation for pre-surgical screening by PhD, ABPP, and Clinical Health Psychologist. MMPI-2-RF indicates somatic complaints and emotional and thought dysfunction. Somatic complaints include preoccupation with poor health, malaise, and neurological symptoms. Emotional Internalizing finding relate to anxiety, dysfunctional thinking relates to ideas of persecution. Medical treatment recommendations and client management suggestions state: based on this pre-surgical psychological screening she is CLEAR for the surgery, with a FAIR prognosis for pain reduction and functional improvement.

On March 3, 2011 there is notification of denial of service from X28294, Initial Clinical Reviewer; the notification was carbon copied to Back Institute, WC, and Attorney. The services denied were for Low Back Disk Surgery and nerve test add-o. The notification recommendation is to non-certify right L5-S1 discectomy with one day length of stay. Under pertinent clinical information/rationale the notification states: The problem is described as that of back symptoms in an obese (260 pounds) female. The subsequent treatment included physical therapy, chiropractic, work hardening, medications and epidural steroid injections without improvement. Nothing objectively abnormal was noted on the neurological examination of the areas concerned initially; recently right EHL and anterior tibial weakness is described. Give way muscular weakness noted. Likely psychological overlay mentioned. MRI 8/25/09 was described as indicating the presence of mild degenerative changes at L4-5 and L5-S1 with small disc bulges at each level. The repeat MRI describes a disc extrusion at L5-S1 and is described as being "close" to both S1 nerve roots. Electrodiagnostic study 7/18/09 was stated to describe the presence of right S1 radiculitis and right sural sensory neuropathy with peroneal motor neuropathy at the fibular head bilaterally. The claimant was not felt to be a surgical candidate by Dr.. The claimant is a smoker. Nothing definitely objectively abnormal was noted on the neurological examination of the areas concerned although some weakness has been recently described. All weakness prior was apparently make break in quality. No definite surgical lesion is noted on imaging study as not definite nerve root compression is described. The procedure, considering the information available for review, is not medically indicated, reasonable or necessary.

On March 22, 2011 there is notification of reconsideration denial of service from X28294, Initial Clinical Reviewer; the notification was carbon copied to Back Institute, WC, and, Attorney. The notification recommendation is to non-certify right L5-S1 discectomy with one day length of stay. Under pertinent clinical information/rationale the notification states: This injured worker with date of onset attributes her problem to a slip and fall, and has been treated with physical therapy, chiropractic, work hardening, medications, and epidural steroid injections (no benefit). On examination, Dr. noted she neurologically normal, while Dr. and Dr. felt she had EHL weakness; she is described as being short and weights 260 pounds. Psychological evaluation has indicated severe depression, anxiety, and pain avoidant behavior. MRI 8/25/09 reported mild degenerative changes at L4-5 and L5-S1 with small disc bulges at each level, a repeat study describes a disc extrusion at L5-S1 "close" to both S1 nerve roots. Electrodiagnostic

study 7/18/09 reported right S1 radiculopathy and right sural sensory neuropathy with peroneal motor neuropathy at the fibular head bilaterally. Claimant has a strong history of psychological issues, and has not responded to any treatment so far provided. There is a discrepancy about whether she shows neurological change. Considering her psyche, habitus, apparent pain avoidance, and discrepancies about neurological findings, it seems highly unlikely that the requested intervention will be beneficial, so it cannot be considered reasonable or medically necessary.

PATIENT CLINICAL HISTORY:

The claimant is a female with a history of pulmonary embolus status post childbirth and asthma. She is status post Cholecystectomy and three C-Sections, depression, sexual difficulty, obesity and is positive for smoking less than one pack of cigarettes per day.

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

The previous decisions are overturned. The claimant's neurological exams are inconsistent and the claimant history of psychological issues, but the claimant has exhausted conservative care and the EMG was positive for radiculopathy. Based on the ODG Guidelines the previous decisions are overturned.

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)