

# CASEREVIEW

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Notice of Independent Review Decision

**[Date notice sent to all parties]:** November 21, 2012

**IRO CASE #:**

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

Left Decompressive Lumbar Laminectomy L5-S1

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

This physician is a Board Certified Orthopedic Surgeon 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

09/16/11: MRI Lumbar Spine w/o contrast interpreted  
09/16/11: MRI Sacrum w/o contrast interpreted  
10/24/11: Evaluation  
11/09/11: Evaluation  
11/10/11: PT Evaluation  
11/29/11: Re-evaluation  
11/30/11: PT Daily Progress Note  
12/01/11: PT Daily Progress Note  
12/02/11: Procedure Note  
12/05/11: PT Daily Progress Note  
12/07/11: PT Daily Progress Note  
12/09/11: PT Daily Progress Note  
12/12/11: PT Daily Progress Note  
12/16/11: Re-evaluation

12/20/11: Re-evaluation  
01/09/12: Therapy Re-evaluation  
01/17/12: Re-evaluation  
01/23/12: PT Daily Progress Note  
01/27/12: PT Daily Progress Note  
01/30/12: Evaluation  
02/01/12: PT Daily Progress Note  
02/02/12: PT Daily Progress Note  
02/06/12: PT Daily Progress Note  
02/10/12: EMG/NCV of the left lower extremity  
02/16/12: Re-evaluation  
02/21/12: Re-evaluation  
03/15/12: Operative Report  
03/22/12: Re-evaluation  
03/27/12: Re-evaluation  
04/12/12: Operative Report  
04/24/12: Re-evaluation  
04/26/12: Re-evaluation  
05/21/12: Re-evaluation  
05/23/12: Psychosocial Screening  
06/15/12: Weekly Summary  
06/15/12: Psychoeducational Group Note  
06/18/12: Re-evaluation  
06/22/12: Weekly Summary  
06/22/12: Psychoeducational Group Note  
06/27/12: Weekly Summary  
06/27/12: Functional Capacity Evaluation  
07/05/12: Re-evaluation  
07/20/12: Weekly Summary  
07/20/12: Psychoeducational Group Note  
07/27/12: Weekly Summary  
07/27/12: Psychoeducational Group Note  
07/30/12: Re-evaluation  
08/01/12: Re-evaluation  
08/07/12: Evaluation  
08/15/12: MRI Lumbar Spine w/wo contrast  
09/06/12: Re-evaluation  
09/07/12: Re-evaluation  
09/25/12: UR performed  
10/09/12: Re-evaluation  
10/22/12: UR performed

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who was injured on xx/xx/xx while working. She was riding on a quad and the quad had fallen backwards, causing the claimant to land on her sacrum. She was initially seen where she was diagnosed with a bruise and strain and given a prescription for Hydrocodone.

On September 16, 2011, MRI of the Lumbar Spine, Impression: 1. L5-S1 annular tear and L4-L5 and L5-S1 disc herniations. 2. L4-L5 and L5-S1 mild bilateral neural foraminal narrowing.

On September 16, 2011, MRI of the Sacrum, Impression: S2 level bilateral sacral bone contusion without discrete fracture and with adjacent right piriformis muscle strain or contusion.

On October 24, 2011, the claimant was evaluated for a chief complaint of low back and bilateral lower extremity pain. On physical examination there was negative Lasegue's, slumps, and Gower signs, but she was complaining of low back pain with the maneuvers. Sensory exam was within normal limits to bilateral nerve root dermatomal patterns. Motor strength was 5+ bilaterally including hip flexion, knee flexion, extension, foot dorsi, and plantar flexion. Reflexes were 2+ bilaterally including Achilles and patellar reflexes. There was significant pain to palpation right-sided lumbar paraspinous muscles. There was also significant pain bilateral SI joints, left side greater than right. Diagnosis: Low back pain, disordered sacrum, lumbar radiculitis, and myositis myalgia. Recommendations: Continue medication including Celebrex 200 mg, Lyrica 75 mg, Tizanidine 4 mg, and Ultram 50 mg. Si joint injections bilaterally and TENS unit.

On November 10, 2011, the claimant had a physical therapy evaluation by Kevin Mark, PT who recommended she be seen three times a week times three weeks for therapeutic exercise, modalities, and lumbar derangement #5 protocol to include mobilization as indicated plus aquatic therapy.

On December 2, 2011, Procedure performed: Diagnostic and Therapeutic Bilateral Sacro-Iliac Joint Arthrography with Injection of Anesthetic and/or Steroid.

On December 16, 2011, the claimant was re-evaluated who reported that she had wonderful relief for two weeks following the sacroiliac joint injections. Her pain returned and was significant and described as tightness in her low back with pain going down the posterior aspect of her thigh all the way down to her foot. On physical exam her sensory was within normal limits to bilateral nerve root dermatomal patterns. Reflexes were 2+ and brick bilaterally. There was positive Laseque's, slumps, and Gower's on the left to 90 degrees. It did cause shooting pain going down the posterior thigh, calf, and into the foot following S1 nerve dermatome. Motor strength was 5+ bilaterally. Plan: opined that the left lower extremity radicular pain was a separate pain generator and felt that now that the sacroilitis was improving the pain from the L5-S1 area was now causing her problems. He recommended L4-L5 and L5-S1 transforaminal epidural steroid injection on the left. She was prescribed Silenor 6 mg and tizanidine was discontinued.

On December 20, 2011, the claimant was re-evaluated who reported the ESI and therapy had helped. She still had pain to the right buttocks with some radiation down the left leg. Recommendations: 8 more session of PT.

On January 9, 2011, the claimant had a physical therapy re-evaluation in which it was reported that she now had full ROM and her end range pain with extension did reduce with manual therapy. It was stated that her program would have to be progressed to a high level in order to prepare her for full duty. Plan: Continue with lumbar derangement protocol, continue with home exercises, continue plan of care as per physician's prescription.

On January 30, 2012, the claimant had a surgical evaluation who on physical examination found no paraspinous spasm, no PSIS tenderness, and full ROM. She did have some left-sided SI joint tenderness to deep palpation. No sciatic notch tenderness. She had a positive straight leg raise on the left. No significant atrophic changes. Strength to lower extremities was 5/5 except for left EHL, which was about 4+ to 5-/5. Deep tendon reflexes were 2/4 bilaterally and symmetrical. Grossly intact to light touch sensation to both lower extremities. Diagnosis: Displacement of intervertebral disc site unspecified without myelopathy. Recommendations: EMG/NCV of the left lower extremity as well as an MRI of the pelvis. Referred to for transforaminal epidural injections at L4-L5 and L5-S1.

On February 10, 2012, the claimant underwent an EMG/NCV of the left lower extremity performed. Impression: There is no evidence of axon injury at this time. No evidence of lumbosacral radiculopathy by EMG. Normal test in the left leg.

On March 15, 2012, Operative Report. Postoperative Diagnosis: Severe low back pain and left lower extremity pain and discomfort severe secondary to herniated pulposus resulting in neuroforaminal stenosis at L4-L5 and L5-S1, left. Procedure: Left transforaminal steroid injections at L4-5 and L5-S1.

On March 22, 2012, the claimant was re-evaluated who reported she continued to have some burning sensation in her low back, especially in her buttock on the left side. believed this was a result of the injection.

On April 12, 2012, Operative Report. Postoperative Diagnosis: Severe low back pain and left lower extremity pain and discomfort severe secondary to herniated pulposus resulting in neuroforaminal stenosis at L4-L5 and L5-S1, left. Procedure: Left transforaminal steroid injections at L4-5 and L5-S1.

On April 24, 2012, the claimant was re-evaluated who reported her symptoms were still persistent and she was still having weakness in her left leg. On physical exam she had mild tenderness to the left paravertebral musculature. Discomfort with forward flexion. And negative straight leg raise. Plan: See again for surgical consult, refill Celebrex 200 mg and TENS unit.

On April 26, 2012, the claimant was re-evaluated who recommended work conditioning/work hardening.

On May 23, 2012, the claimant underwent psychosocial screening who reported that the claimant did not appear to be suffering from any significant level of

depression. It was recommended that staff be aware that the claimant may have a high tolerance for pain and therefore should be monitored more carefully that she does not exceed prescribed limits of the program. It was also reported that the claimant verbalized a significant desire to return to work as soon as possible. Work hardening was recommended.

On June 27, 2012, the claimant underwent an FCE. Based on the results, her current physical demand level was Medium PDL. Her required PDL for return to work is Very Heavy. Limitations Preventing Return to Full Duty: Decreased squatting, kneeling, lifting and carrying, as well as continued pain to the lumbar pain with all explosive movements required to return to full work duty. Recommendations: Continue with current Work Hardening Program.

On July 30, 2012, the claimant was re-evaluated who reported she had completed work hardening and had been cleared for moderate-to-heavy work. However, the claimant continued to be frustrated by a deep left buttock pain and continued to focus on surgical interventions. On physical examination she was tender on very deep palpation, really more or less along the left lateral sacral area, deep in the gluteus area. did perform a trigger point injection in the region of point of maximal tenderness in the left gluteus. He refilled her Zanaflex 4 mg, Celbrex and Tramadol.

On August 1, 2012, the claimant was re-evaluated who reported she had an increase in sciatic radiation down both legs after the trigger point injection. Plan: Referral for consideration for lumbar surgery.

On August 7, 2012, the claimant was evaluated who found on physical examination normal gait, mild globally decreased range of motion of the L-spine without significant pain with active range of motion testing. No dermatomal specific sensory loss. No motor weakness. Positive straight leg raise on the left side. X-rays obtained demonstrated mild scoliosis. Lateral views showed fairly good lumbosacral lordosis. Disc space narrowing appeared to be more significant at L5-S1. Flexion and extension vies did not appear to show any true segmental instability. The oblique views did not show any obvious spondylolysis. There did not appear to be significant facet arthropathy. Diagnosis: Chronic back pain with left leg radiculopathy. Recommendations: Closed MRI.

On August 15, 2012, MRI Lumbar Spine, Impression: Degenerative spondylosis of the lower lumbar spine as described above with a 0.4 cm central disk protrusion at L5-S1, which does not have mass effect on the traversing nerve roots.

On September 6, 2012, the claimant was re-evaluated who reported she continued to have back pain with left leg pain and radiculopathy complaints. After reviewing the MRI he recommended a simple decompressive procedure at L5-S1.

On September 25, 2012, performed a UR. Rationale for Denial: The rationale for a 3 day hospitalization for a regular uncomplicated laminectomy without fusion is

not supported as a medical necessity. The records for review noted a normal EMG and the neurological exam was normal per as of 8-1-12. The MRI of 8-15-12 only showed a small disc protrusion at L5-S1 without nerve root entrapment. The need for any decompression surgery is not validated by the imaging or the neurological exam.

On October 9, 2012, the claimant was re-evaluated who reported on physical examination she continued to have a positive straight leg raise with no other neurological abnormalities. He stated that while the claimant did not have severe stenosis, she did have a herniated disc and had a radiculopathy that fits with that segment in her back. She had tried all nonsurgical care and continues to have complaints. He stated that the procedure he was requesting was a simple laminectomy and discectomy procedure, which is supposed to improve leg radiculopathy complaints.

On October 22, 2012, performed a UR. Rationale for Denial: The requested left decompressive lumbar laminectomy at L5-S1 is not recommended as medically necessary based on the clinical documentation provided for review and current evidence based guidelines. The patient has continued to report severe low back pain. The most recent clinical note was unclear regarding any significant component of lower extremity pain. The patient was reported to have a positive straight leg raise to the left; however, it is unclear whether this orthopedic test reproduced any lower extremity symptoms. In regards to the patient's imaging, there was insufficient evidence of any significant spinal canal stenosis that would reasonably benefit from laminectomy procedures. MRI studies revealed a small disc bulge at L5-S1 contributing to mild foraminal stenosis only. No impingement on the nerve roots was present on the imaging studies. Prior electodiagnostic studies do not reveal evidence of lumbar radiculopathy. Given the lack of objective evidence to support a diagnosis of lumbar radiculopathy, the requested lumbar laminectomy at L5-S1 would not be recommended as medically necessary.

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

The previous adverse determinations are upheld. After review of the medical records provided, there is no indication of radiculopathy. There was a negative EMG, no positive neurological findings other than positive straight leg raise. The straight leg raise was not fully described or explained by the claimant's physician. There was no indication on MRI of nerve impingement to correlate with any radicular type findings. Based on the findings within the medical records and based on ODG criteria, the request for Left Decompressive Lumbar Laminectomy L5-S1 is not found to be medically necessary.

### **PER ODG:**

#### **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)