

AccuReview
An Independent Review Organization
Phone (903) 749-4271
Fax (888) 492-8305

Notice of Independent Review Decision

DATE OF REVIEW: February 2, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Posterior Lumbar Discectomy @ L4-L5 63030 69990

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

This physician is Board Certified in Neurological Surgery 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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who injured her lower back while xxx and xxxx on xx/xx/xx. She was originally treated with oral corticosteroids, Vicodin, Soma, and Lyrica without any significant relief. She also had physical therapy and an ESI.

10-04-11: New Patient Evaluation by PA for MD at xxxx xxxx. Pain was rated as 8/10 and was in the L4-5 and L5-S1 with radiation to right buttock, posterior thigh, and posterior calf. The pain was described as numbness, ache, and stabbing pain. On physical examination she was tender to palpation, right buttock, L5-S1. Flexion was limited with increased back and leg symptoms, fingertips to proximal extremities. She had decreased sensation lateral thigh on the right to light touch. Straight leg raise on the right at 45 degrees reproduced right proximal leg and increased numbness in her right foot. Negative straight leg raise on the left. Strength was rated 5/5 to manual motor testing in the lower extremities. Toe and heel walk unremarkable. Diagnosis: Right lumbar radiculopathy and mechanical low back pain, probable disc herniation. A MRI of the lumbar spine was ordered along with standing x-rays.

10-13-11: MRI Lumbar Spine without Contrast. Impression: 1. At L4-5 there is a large right posterior lateral disk extrusion severely narrowing the right lateral recess with mass effect upon the L5 nerve root. There is moderate spinal canal stenosis. 2. Milder degenerative findings at L3-4 and L5-S1 causing mild degrees of spinal canal and foraminal stenosis as described above.

10-14-11: Follow-up evaluation with PA for MD at xxx xxxx. There was no change in her physical examination, but reflexes were listed to be 2+ and symmetrical in the lower extremities. Diagnosis: Right L5 radiculopathy and disc herniation, right L4-5. She was scheduled for an epidural steroid injection, right L4-5. Following the injection, it was recommended that seeing a McKenzie-trained therapist would be beneficial.

10-24-11: Procedure Report by MD. Post-operative diagnosis: Lumbar radiculopathy. Procedure: Right L4-5 Lumbar Epidural Steroid Injection.

11-08-11: Follow-up evaluation with PA for MD at xx xxxx. It was reported that the claimant received no relief, "in fact it made it worse" from the ESI. She continued to have pain in the L4-5 level with radiation into the right buttock, lateral thigh, and lateral calf. On physical examination she had difficulty transitioning from sitting to standing. She was tender to palpation at the right buttock, L4-5 level. Flexion was extremely limited fingertips to knees with increased right buttock and lateral thigh pain on the right. Extension reproduced low back pain and proximal right lateral thigh and right buttock pain. Straight leg raise on the right at 45 degrees reproduced right leg symptoms. Negative

straight leg raise on the left. Strength was rated 5/5 to manual motor testing in the lower extremities. She had difficulty with heel walking on the right side. , PA reported that the claimant had failed conservative treatment consisting of physical therapy, nonsteroidal anti-inflammatory drugs, oral corticosteroids, epidural steroid injection, and pain medication. He was going to have her follow-up with Dr. to discuss possible surgical intervention.

11-09-11: Initial Consultation with MD at xxxx xxxxx. On physical examination straight leg raise on the left side was really negative. No pain down the left side of her leg. The patient's straight leg raise on the right side was much more significant producing right-sided back pain, right-sided buttock pain, and right-sided thigh pain. Strength examination, right anterior tib 4/5 versus 5/5 on the left. Plan: A right-sided L4-5 microdiscectomy.

11-17-11: UR performed by MD. Reason for Denial: As per medical records, the patient complains of left sided back pain. Physical examination revealed positive SLR on the right, imaging findings include a 10/13/11 MRI of the lumbar spine identifying a L4-5 large right posterior lateral disc extrusion severely; narrowing of the right lateral recess with mass effect upon the L5 nerve root; and milder degenerative findings at L3-S1 causing mild degrees of spinal canal and foraminal stenosis. Conservative treatment includes right L4-5 lumbar Epidural Steroid injection on 10/24/11, (response not provided) and PT. However, there is no (clear) documentation of a least 1 symptom/finding (unilateral foot/toe/dorsiflexor weakness/atrophy or unilateral hip/lateral thigh/knee pain) which confirms the presence of radiculopathy, associated clinical findings such as loss of relevant reflexes, muscle weakness and/or atrophy of appropriate muscle groups, loss of sensation in the corresponding dermatome(s), and failure of additional conservative treatment (including activity modification). Therefore, the medical necessity of the request is not substantiated.

11-30-11: Office Visit with MD at xxx xxxx. Subjective complaints: 1. Mechanical back pain, left and right. 2. Bilateral leg pain. On the right side, it is in the buttock, lateral thigh, lateral calf, and lateral foot. On the left side, which is a newer component, which is in the buttock and lateral thigh and stopping around the knee. On physical examination straight leg raise on the left side caused left-sided buttock pain and thigh pain. Straight leg raise on the right side was much more limited because of increasing pain in the buttock, thigh, and calf. Strength examination, slightly weaker on the right anterior tib 4/5 versus 5/5 on the left. Reflex was symmetric at the knees and ankles. Dr. again recommended bilateral L4-5 microdiscectomy.

12-22-11: Office Visit with MD at xxxxxx xxxx. On strength examination, right over left, quad was 5/5, anterior tib was about 4/5, EHL was 4/5 and gastroc was 5/5. Reflexes were symmetrical in the knees and ankles. Measurement of her calf 10 cm proximal to the medial malleolus was 28.5 on the right and 29 on the left side, so only 0.5 cm difference between the two. Dr. again state the claimant

deserved surgery which would be a bilateral L4-5 microdiscectomy, but would probably just do a laminotomy on the left side.

12-23-11: UR performed by MD. Reason for Denial: The medical report dated 11/30/11 indicates that the patient has low back pain. On physical examination, there is positive straight leg raising test bilaterally, more on the right, weakness on the right and normal reflex. The medical report failed to objectively document exhaustion and failure of conservative treatment such as activity modification, home exercise training, oral pharmacotherapy, and physical therapy. There are no noted VAS pain scales, and physical therapy notes documenting a lack of progress in several attempts. There is no documentation provided with regard to the failure of the patient to respond to recent evidence-based exercise program in the reviewed report. There is documentation of failure with optimized pharmacological treatment in managing the pain. There is no objective evidence that the patient is unlikely to gain clinically significant functional response from continued treatment from less invasive modalities. The signed radiologist's analysis of the MRI of the lumbar spine was not submitted for review. The maximum potential of conservative treatment done was not fully exhausted to indicate a surgical procedure. Hence, the medical necessity of this request has not been facilitated. Addendum: I was able to speak with Dr.. Dr. stated that he does not measure the circumference of his claimant's legs. There is no finding of atrophy in this claimant, but Dr. will bring her back in for a measurement. The medical records provided for review did not document unequivocal evidence of radiculopathy and the request should not be certified at this time.

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

The previous adverse determinations have been partially overturned. My opinion, based on the medical records and the MRI report, is that this claimant will require a posterior micodiscectomy at L4-5 on the right. The clinical picture is of a right L5 radiculopathy and the MRI shows 7 mm herniated disc at the same level on the right.

The claimant meets the following ODG indications for surgery. I) Symptoms/Findings: There was documented mild unilateral anterior tibialis weakness and mild atrophy. On the 11/09/11 and 11/30/11 physical examinations by Dr., it was documented that the claimant had right anterior tibialis weakness 4/5 and positive SLR on the right. On Dr. 12/12/11 examination he documented right anterior tibialis and EHL weakness of 4/5. Dr. also documented calf measurement on the right to be 28.5 cm and 29 cm on the left, indicating mild atrophy of .5cm. II) Imaging Studies: The claimant did have a positive MRI that revealed at L4-5 a large right posterior lateral disk extrusion severely narrowing the right lateral recess with mass effect upon the L5 nerve

root. III) Conservative Treatments: The claimant has failed conservative treatment including physical therapy, oral corticosteroids, muscle relaxants, pain medications, and ESI injection.

Based on the above, the request for a Posterior Lumbar Discectomy @ L4-L5 63030 69990 is only found to be partially medically necessary. The claimant will only require a posterior microdiscectomy on the right at L4-L5, and therefore, the adverse determinations are partially overturned.

ODG:

Discectomy/ laminectomy

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.

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](#) (\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](#))

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)**