

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** OCTOBER 31, 2013

**IRO CASE #:**

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

Medical necessity of proposed Hemilaminotomy/Microdiscectomy at bilateral L5/S1 (63030)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

### **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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.10	63030		Prosp	1			Xx/xx/xx	xxxxx	Upheld

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

TDI-HWCN-Request for an IRO-20 pages

Respondent records- a total of 168 pages of records received to include but not limited to: records 6.13.13-10.9.13; Surgical notes 7.31.13; note 7.30.13; records, 7.8.13-8.12.13; Medical Script 6.11.13, record 6.4.13; various DWC forms; letters 8.23.13, 8.29.13; HCFA 1500 DOS 7.11.13, 7.9.13; Performance Therapeutics records 7.9.13, 7.11.13; Medical Review Stream reports 8.23.13, 8.29.13; DI letter 10.11.13; Request for an IRO forms; ODG Guidelines; MRI Lumbar Spine 6.7.13; Med Bill Impact 6.26.13

Requestor records- a total of 61 pages of records received to include but not limited to: PHMO Notice of an IRO; records 6.19.13-10.9.13; Surgical notes 7.31.13; records, 7.8.13-8.12.13; note 7.30.13; Medical Script 6.11.13, record 6.4.13; various DWC 73; request for an IRO forms

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

The injured employee is a gentleman who reported an industrial injury to the low back on xx/xx/xx. He reported twisting the low back, developing back pain. The past medical history is significant for previous right ankle surgery in xxxx.

The injured employee was evaluated on June 4, 2013, with subjective complaints of low back pain. On physical examination, there was tenderness to the midline of the lumbar spine from L4 to S1 with bilateral paraspinal spasms. There was tenderness with range of motion. Deep tendon reflexes were 2+. There was a normal gait and normal heel-to-toe walking. The clinical assessment was lumbar sprain. The recommendation was for an MRI of the lumbar spine.

An MRI of the lumbar spine on June 7, 2013, reported:

1. There is early degenerative changes with bulge of the annulus and disc at L3-L4 and L4-L5,
2. At L5-S1, there is posterior disc herniation central in location with fragment estimated at 5 mm x 7 mm, and
3. The spinal canal is marginally small, probably congenitally, and there is no bony stenosis.

On June 19, 2013, the injured employee was evaluated. There were subjective complaints of low back pain and occasional lower extremity pain. On physical examination, there was no tenderness to palpation throughout the cervical, thoracic, or lumbar spine. There was full range of motion. Strength was 5/5 in all upper and lower extremity motor groups. There was normal sensation to light touch in the C5 through T1 distribution and L1 through S1 distribution, except decreased sensation in the right lateral leg and right lateral thigh and decreased sensation in the right lateral foot that was from a previous surgery. Deep tendon reflexes were 2+ and equal. The recommendation was for physical therapy.

performed a medical evaluation on July 8, 2013. There were subjective complaints of back and bilateral leg pain. The current medications included cyclobenzaprine, nambutone, Naproxen, and Norco. On physical examination, there was tenderness to palpation of the lumbosacral junction mildly increased with end range of repetitive extension and repetitive forward flexion, includes left buttock pain and left posterior thigh pain. Straight leg raising was positive bilaterally at 60 degrees with posterior thigh pain. There was no atrophy. There was normal muscle tone. There was 1+ Achilles and 2+ patellar reflexes bilaterally. The clinical assessment was symptomatic L5-S1 disc protrusion superimposing pre-existing L5-S1 disc degeneration. The recommendation was for L5-S1 bilateral epidural steroid injections.

performed a bilateral transforaminal epidural steroid injection on July 30, 2013. Postoperative diagnosis was bilateral L5 and S1 radiculopathy.

The injured employee followed up on August 12, 2013. The injured employee reported three days of pain relief from the epidural steroid injection, but the symptoms returned. On physical examination, there was tenderness to the lumbosacral junction mildly increased with extension and decreased with forward flexion. Straight leg raising produced mild bilateral hip pain, left greater than right. There was no atrophy and normal muscle tone.

On a follow-up on August 12, 2013, there were subjective complaints of low back and bilateral lower extremity pain. The recommendation was for a left L5-S1 laminectomy.

On August 23, 2013, performed a Peer Review which stated the Guidelines indicate surgery may be considered after failure with conservative treatment when symptoms and objective findings confirm the presence of radiculopathy at the planned operative level. Other than decreased sensation over the right lateral foot, a finding that was notably attributed to unspecified prior surgery, neurological deficits supportive of radiculopathy at L5-S1 were not noted in the latest physical examination clinically justifying the contemplated surgery. Also, frank

nerve root compression, lateral disrapture, or lateral stenosis at L5-S1 was not documented in the June 7, 2013, MRI report. Based on these grounds, the medical necessity request was not substantiated.

On August 29, 2013, performed a Peer Review. He stated that while the injured employee has low back pain and bilateral leg pain, the records submitted for review had not contained specific objective findings, such as motor deficits and positive provocative tests to support the diagnosis of L5-S1 radiculopathy. The injured employee had decreased sensation over the right lateral foot, which was probably attributed to the unspecified prior surgery; however, recent electrodiagnostic studies of the lower extremities were not submitted to rule out any pre-existing peripheral neuropathy versus radiculopathy. In agreement with the previous determination, the medical necessity as requested has not been substantiated. Given the above request for appeal, request for one Hemilaminotomy/Microdiscectomy at bilateral L5-S1, is not certified.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

**RATIONALE:**

As noted in the Division-mandated Official Disability Guidelines, after reviewing the mechanism of injury, the multiple medical records available for review, the initial and subsequent medical evaluations, the two previous Peer Review denials and the peer-reviewed, evidence-based Official Disability Guidelines Low Back Chapter, updated October 9, 2013, would not support medical necessity of proposed Hemilaminotomy/Microdiscectomy at bilateral L5-S1 to be medically necessary. Peer-reviewed Official Disability Guidelines require objective evidence of radiculopathy on physical examination and supported by diagnostic imaging. There is no physical examination reporting any neurological deficits of radiculopathy at L5-S1 that would clinically justify the requested surgery. There is no documentation of muscle weakness in a myotomal distribution, decreased in a dermatomal distribution, or loss of relevant reflex. The MRI of the lumbar spine on June 7, 2013, reported no nerve root impingement. There are no electrodiagnostic studies reporting any lumbar radiculopathy.

ODG Low Back (updated 10/09/13)

ODG Indications for Surgeryä -- 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
- III. Diagnostic imaging modalities, requiring ONE of the following:
  - A. MR imaging
  - B. CT scanning
  - C. Myelography
  - D. CT myelography & X-Ray
- IV. 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)

**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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)