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Notice of Independent Review Decision

DATE: March 29, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar Laminectomy and Foraminotomy at L4-L5

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is certified by the American Board of Orthopaedic Surgery with over 42 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:
05/11/12: 3V Cervical Spine and 2V Lumbar Spine report
05/11/12: Lumbar Spine X-ray report
05/11/12: MRI Lumbar Spine without Contrast report
05/16/12: EMG Nerve conduction Study
07/19/12: Followup Visit
08/14/12: Operative Report
01/10/13: Manual Muscle Strength Exam Lumbar
01/10/13: X-ray Cervical Spine report interpreted
01/11/13: Orthopedic Consult
01/25/13: Order Form for MRI C-Spine
01/25/13: Office Note
01/31/13: Preauthorization Request
02/01/13: Surgery Reservation Sheet
02/06/13: UR performed
02/11/13, 02/28/13: Orthopedic Report
02/19/13: Reconsideration Request
03/15/13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who fell down steps backwards while at work on xxxxxx.

05/11/12: 3V Cervical Spine and 2V Lumbar Spine report. IMPRESSION: Negative radiographic assessment for recent fracture, dislocation, or gross osseous aggressive process, to the extent visualized. The AP cervical view reveals curvature due to muscle spasm. The lateral cervical projection reveals straightening of the cervical spine possibly due to muscle spasms as well as diminished disc space at the C5-C6 and C6-C7 levels possibly due to disc injury. The lateral lumbar projection reveals straightening of the lumbar lordosis possibly due to muscle spasms. The lateral lumbar view reveals moderate-severe diminished disc space at the L4-L5 and L5-S1 levels possibly due to disc injury.

05/11/12: Lumbar Spine X-ray report. IMPRESSION: There is no evidence of fracture or subluxation. There is marked narrowing of the disc space at L4-L5 associated with considerable facet arthropathy. Large anterior osteophyte is seen at this level. At L5-S1, there is a 50% narrowing of the disc space with facet arthropathy bilaterally.

05/11/12: MRI Lumbar Spine without Contrast report. FINDINGS: Disc space narrowing is seen at the L4-L5 level with borderline disc space narrowing posteriorly at the L5-S1 level. At L4-L5, there is a posterior 3 mm disc protrusion/herniation with posterior marginal spondylosis pressing on the thecal sac and narrowing the medial aspect of the neural foramina bilaterally. There is bilateral facet hypertrophy at the L4-L5 level narrowing the lateral recess on each side with overall spinal stenosis at that level. IMPRESSION: Multilevel disc pathology of the lumbar spine is seen as described including overall spinal stenosis at the L4-L5 level.

05/16/12: EMG Nerve Conduction Study. IMPRESSION: Based on the review of the EMG and Nerve Conduction Studies of the lower extremities and the lumbar paraspinals, this patient has findings consistent with a left radiculopathy to the L3, bilateral radiculopathy to L4 and L5, and a right radiculopathy to S1.

08/14/12: Operative Report. POSTOPERATIVE DIAGNOSIS: Lumbar radicular syndrome secondary to spinal stenosis at L4-L5 and L5-S1. PROCEDURES PERFORMED: Caudal epidural steroid injection at L4-L5 performed under fluoroscopic guidance and epidurogram.

01/11/13: The claimant was evaluated. She presented with low back pain rated 8/10 with constant pain, discomfort with side-to-side movements, soreness, and stiffness. She had lower extremity symptoms including numbness, tingling, and weakness. On physical exam, she had difficulty getting onto the exam table. There was severe tenderness in the mid to lower lumbar region with decreased range of motion with flexion and extension. She had right levels of pain with right and left lateral bending. SLR positive for leg pain and back pain bilaterally. Motor strength was weakened in knee flexors, knee extensors, and extensor hallucis

longus bilaterally. She had paresthesias along her L5 distribution bilaterally. Her reflexes were blunted in her patellae and Achilles. Her gait was slow. She was unable to heel-to-toe walk, walk on toes, and walk on heels due to discomfort in both lower extremities and difficulty walking. IMPRESSION: Stenosis and neurogenic claudication with disc derangement, L4-L5 with lower extremity radiculopathy. PLAN: With regard to the patient's lumbar spine, she continues to remain symptomatic. She has completed physical therapy, oral anti-inflammatories, and lumbar epidural steroid injections. The patient's physical exam is consistent with radiculopathy in her lower extremities. This is consistent with her MRI film and report. We are recommending a lumbar laminectomy with foraminotomy at L4-L5 bilaterally.

02/06/13: UR performed. RATIONALE: ODG indicate there must be evidence of radiculopathy on physical examination which is corroborated by imaging studies. This claimant has no objective evidence of radiculopathy with muscle atrophy or loss of relevant reflex. The MRI reported no nerve root compression. There was no documentation of lower levels of care of use of non-steroidal anti-inflammatories, other analgesic treatment, muscle relaxants, physical therapy, or manual therapy. The request for a lumbar laminectomy and foraminotomy at L4-L5 is not certified.

02/11/13: reviewed the claimant's clinic history. It was noted that on 01/11/13, she had a high level of low back pain with pain radiating into her lower extremities. She complained of numbness, tingling, and weakness. It was noted that she had been through an abundant course of nonoperative treatment including physical therapy, oral anti-inflammatories, and lumbar epidural steroid injection. She had participated in activity medication with little relief. It was noted that physical exam revealed severe tenderness in her mid-lower lumbar region with high levels of pain with right and left lateral bending. Straight leg raises were positive for leg pain and back pain bilaterally. Her motor strength was weakened in knee flexors, knee extensors, and extensor hallucis longus. She had paresthesias along her L5 distribution. Her reflexes were blunted in her patellae and Achilles. "Therefore, the patient does show radiculopathy on physical examination, from reflex changes to motor strength weakness and paresthesias." EMG revealed radiculopathy. "After reviewing the patient's MRI personally, there appeared to be nerve impingement upon the L4 and L5 nerve root areas bilaterally."

02/28/13: The claimant was evaluated. It was noted that she had been participating in at-home physical therapy and increasing her mobility with some relief since her last visit. It was also noted that she underwent a hardware block in the past, which gave her 100% relief. She presented with low back pain that she rated as 7/10. She complained primarily of axial mechanical back pain and pain over her incision site area. On physical exam, there was tenderness over her incision site in the lumbar spine with decreased range of motion with flexion and extension. She had high levels of pain with right and left lateral bending. Her lower extremity motor strength and sensation were intact. Her reflexes were 2+ and symmetric. IMPRESSION: Painful hardware of the lumbar spine. PLAN: The patient had good results following her hardware block. We will proceed with

hardware removal at her convenience. The patient's medications were renewed today. These medications are medically necessary to treat the symptoms naturally resulting from the patient's compensable injury.

03/15/13: UR performed. RATIONALE: Based on ODG, there must be evidence of a radiculopathy on physical examination consisting of loss of strength in a specific myotomal pattern, loss of sensation in a specific dermatomal pattern, loss of deep tendon reflexes, and atrophy. All of those findings are not clearly documented on the physical examination findings presented to be reviewed. It should also be noted that the MRI study does not document any specific nerve root compression. There is no indication that lower levels of care, consisting of use of anti-inflammatory medications, has been utilized. Based on all the above factors, the treating provider's request for surgical intervention consisting of a lumbar laminectomy and foraminotomy at the L4-L5 level is not certified at this time. The claimant is noted to have multilevel lumbar radiculopathy on electrodiagnostic studies at the L3 level on the left, bilaterally at the L4-L5 level, and on the right at the S1 level. The physical examination findings do not correspond to all those levels. Therefore, further workup is also felt to be necessary to determine the true pain generating level at this point. The previous non-certification was based on the fact that the physical examination findings did not document evidence of a radiculopathy with muscle atrophy or loss of relevant reflexes. There was also no nerve root compression documented on the MRI study. Therefore, the request was not certified. The treating provider has submitted a reconsideration request, which included an additional letter from February 11, 2013. However, no additional physical examination findings were documented that would result in an overturn of the previous non-certification. At this time, the request is still not certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse decisions are upheld. I agree completely with and their denial of the L4-L5 laminectomy and foraminotomy because of the reasons listed below. There are no positive physical findings that would indicate a specific nerve root radiculopathy. ODG criteria state that there must be 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. She has bilateral straight leg raising, but there is no documented detail on physical exam of what angle or if any other findings, such as whether it is equal on both sides or if one side is more than the other or if it is different when sitting or lying down. The records only indicate it as straight leg raising that causes leg pain. It is not specific to where the leg pain is or what angle is involved. Bilateral weakness in muscle groups is noted, but it certainly does not indicate a specific radiculopathy. Statements such as "numbness in both legs" are not specific for any dermatomal nerve root involvement and would not indicate radiculopathy. Her EMG shows multiple levels from L3 to S1 being involved on both sides. This would not be typical of nerve root impingement and would not diagnose radiculopathy. Her MRI showed some narrowing at the L4-L5 level, but again did not indicate nerve root

compression. Again, on her physical exam, she had generalized back pain, bilateral weakness involving muscle groups, but not being specific for a nerve root level. On 02/28/13, physical exam documented intact motor strength and sensation with 2+ symmetric reflexes. The plan of treatment was for hardware removal, which would not correlate with the requested procedure of Lumbar Laminectomy and Foraminotomy at L4-L5. The request for Lumbar Laminectomy and Foraminotomy at L4-L5 does not meet ODG criteria and is not certified.

ODG:

Discectomy/ laminectomy	**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)**