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Notice of Independent Review Decision

Date: February 19, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar laminectomy and revision at L4-L5 and L5-S1

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

Diplomate American Board of Orthopaedic Surgery
Fellowship Trained in Spine Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

TDI

- Utilization reviews (01/10/13 – 02/01/13)

- Office visits (12/27/93 – 12/11/12)
- Diagnostics (2/21/94 – 4/27/99)
- Therapy (1/3/94 – 7/1/94)
- Procedure (10/24/96)
- Reviews (9/3/98)

- Diagnostics (02/21/94 - 11/02/12)
- Procedure (10/24/96)
- Office visits (10/11/12 - 12/11/12)

ODG has been utilized for the denials

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained injury to his lower back on xx/xx/xx, while he was working and was standing on the drain. He slipped and fell backwards and landed on his back in the mud.

1993 – 1996: On December 27, 1993, evaluated the patient for upper and lower back pain. Examination showed moderate tenderness to the lumbar spine. The patient was undergoing physical therapy (PT). assessed lumbar strain and prescribed Flexeril and Talwin.

On February 17, 1994, evaluated the patient for neck pain radiating to the right arm associated with numbness in the right hand and low back pain. noted the patient had been treated with PT. Examination showed marked cervical and lumbar paraspinal spasm bilaterally with limited range of motion (ROM) and diminished reflexes in the lower extremities, knees and ankles bilaterally. assessed mechanical spine injury manifested by neck and low back pain and right upper extremity and right hand injury and recommended computerized tomography (CT) scan and electromyography (EMG) studies.

On February 21, 1994, CT scan of the lumbar spine showed minimal bulging of the L5-S1 intervertebral disc without evidence of impingement upon the neural elements and minimal spondylitic changes of the L4-L5 and L5-S1 interfacet articulations.

On April 13, 1994, noted the patient had attended 17 sessions of PT from January 3, 1994, through February 14, 1994.

Per physical capabilities assessment dated June 28, 1994, the patient performed at light to light medium physical demand level (PDL) versus medium PDL required by his job. The patient was recommended work hardening program (WHP) to address the deficits.

From June 27, 1994, through July 1, 1994, the patient completed a week of WHP.

On August 15, 1994, an orthopedic surgeon, evaluated the patient for resolving lumbosacral strain. This report is illegible.

On October 6, 1994, assessed maximum medical improvement (MMI) with 5% whole person impairment (WPI) rating. He stated the patient could return to work at light duty on a full time basis presently.

Per DWC-69 dated November 7, 1994, opined that the patient had not reached MMI.

From January 9, 1995, through May 13, 1996, treated the patient with Norgesic Forte, Orudis, BuSpar, Cataflam, Ultram, Norflex, Anaprox and Vicodin ES. recommended magnetic resonance imaging (MRI) of the lumbar spine.

In March 1996, diagnosed herniated L4-L5 disc and herniated L5-S1 disc and refilled Anaprox, Ultram, Norflex and Vicodin ES.

On July 10, 1996, noted the patient had at least three courses of PT over the past couple of years but without any benefit. The patient also had an MRI done on December 28, 1995. He had numbness and tingling into the right leg, into the foot, weakness of his right leg and difficulty emptying his bladder and occasional difficulty with constipation secondary to pain medication. The bladder emptying difficulty had been resolved after changing medications. recommended attending for vocational evaluation and training into a job.

On July 17, 1996, refilled Vicodin ES, Norflex and Anaprox.

On September 27, 1996, performed a designated doctor evaluation (DDE) and assessed MMI as of March 18, 1996, with 9% WPI rating.

On October 3, 1996, refilled Vicodin ES, Norflex and Anaprox DS.

On October 24, 1996, performed laminotomy and discectomy at L5-S1 and laminotomy, discectomy and foraminotomy at L4-L5 on the right.

From December 2, 1996, through October 7, 1998, refilled Vicodin ES, Norflex, Anaprox DS, Tylenol, Motrin and Soma.

1998 – 2003: On September 3, 1998, performed a medical evaluation and opined that the patient had reached MMI. The patient would not require any further surgical procedure and he was capable of returning to work at light to medium PDL.

On February 1, 1999, disagreed with opinions.

On March 31, 1999, refilled Motrin, Tylenol and Soma.

On April 2, 1999, noted the patient continued to have difficulties with pain in his back. He had fibrosis and spondylosis noted on MRI. The fibrosis was present at L4-L5 and L5-S1. He also had a multiple level bilevel facet arthropathy. opined that the patient would not be able to work.

On April 27, 1999, electromyography/nerve conduction velocity (EMG/NCV) study showed findings suggestive of nerve root irritation at the level of L4-L5.

From May 28, 1999, through August 17, 2001, treated the patient with Motrin, Tylenol, Soma, Sonata and Vioxx.

On August 27, 2001, performed a peer review and rendered the following opinions: (1) The medical services as documented October 20, 1999, to present were not causally related to the reported injury of December 17, 1993. Long term use of narcotics such as codeine did not meet the guidelines and was not reasonable. (2) Soma and codeine should not be used together. (3) Since the treating doctor had not furnished the data relating the length of time that the patient had been taking the medications and the dosage regimen of the medications, he was unable to recommend an appropriate weaning for any of the medications. (4) There was no documentation that the current complaints and condition were due to the effects of naturally occurring from the reported injury of December 17, 1993.

On November 5, 2001, noted the patient had shown improvement with the use of transcutaneous electrical nerve stimulation (TENS) unit for pain and discomfort.

From November 5, 2001, through September 22, 2003, treated the patient with Motrin, Tylenol, Soma, Sonata, Viagra and a TENS unit. The handwritten records are illegible.

2004 – 2009: On January 16, 2004, evaluated the patient for low back pain radiating down the right leg. assessed back pain and lumbar radiculopathy and prescribed Tylenol/codeine, Soma and Motrin.

From March 22, 2004, through October 11, 2005, treated the patient with Tylenol/codeine, Soma, Motrin, Vicodin ES and Zyrtec. referred the patient to a chronic pain specialist and recommended starting PT.

Per May 18, 2005, health summary his current medications included enalapril, glyburide/metformin, Viagra, Motrin, Soma and Tylenol with codeine.

On December 7, 2005, performed a medical review and rendered the following opinions: The duration and frequency and type of treatment had been medically necessary and would meet accepted standards of care to treat the work injury. Future treatment would include two to three office visits per year. Medications would remain medically necessary based on the submitted documentation. Diagnostic testing would only be medically necessary if related to the medication use. Surgery did not appear medically necessary. TENS unit appeared to be medically necessary. There was no indication for PT. Maintenance level care would be medically necessary. Use of APAP with codeine, ibuprofen and Soma appeared medically necessary; Ultram for pain would be suggested.

On December 27, 2005, made no changes to the medication regimen and recommended massage, home back strengthening exercises and weight loss.

On February 27, 2006, an orthopedic surgeon, evaluated the patient for low back pain. diagnosed chronic pain syndrome and failed back surgery, requested medical records from office and ordered x-rays of the lumbar spine which would

include lateral flexion/extension views and gave prescription for Lorcet and lumbar back support.

On April 6, 2006, opined that the continued narcotic medication over the period of time was not warranted and this should be addressed through a chronic pain management program.

On September 25, 2006, evaluated the patient for low back pain radiating into the bilateral lower extremities to the feet with numbness, tingling and weakness. The patient stated he had bladder involvement and he urinated more frequently. reviewed diagnostic studies of March 14, 2006, that showed narrowing L5-S1 disc space. He diagnosed chronic lumbar spine pain and bilateral lower extremity radiculopathy, prescribed Motrin and recommended MRI of the lumbar spine.

From November 6, 2006 through July 1, 2009, treated the patient with Flexeril, Vicodin and Soma.

2010 – 2011: On January 6, 2010, prescribed Lorcet and discussed the option of pain management with the patient. Mutual decision was to proceed with trigger point injections (TPIs) in to the bilateral lumbar paraspinals.

On January 26, 2010, had a peer to peer telephone conversation with. did not recommend TPIs.

From June 8, 2010, through May 25, 2011, treated the patient with Lorcet and Amrix. In the past had requested precertification for TPIs that had been denied by the insurance carrier.

On August 15, 2011, MRI of the right hip was unremarkable.

On September 1, 2011, MRI of the lumbar spine showed right central/right subarticular disc herniation at L5-S1 contacting with the transversing right S1 nerve. There was broad-based disc herniation at L4-L5. There was disc protrusion at L3-L4.

From September 7, 2011, through February 1, 2012, evaluated the patient for ongoing low back pain complaints. He reviewed the MRI findings and diagnosed lumbar radiculopathy, multilevel lumbar disc herniation and chronic lumbar spine pain. He treated the patient with Amrix and Lorcet and recommended lumbar epidural steroid injection (ESI) if the patient's symptoms would not alleviate. He recommended home exercise program (HEP).

2012 – 2013: On May 9, 2012, evaluated the patient for persistent low back pain, neck pain and mid-back pain. The pain radiated to the bilateral legs, right more than left. referred the patient to a pain management specialist for further treatment and evaluation.

On October 11, 2012, an orthopedic surgeon, evaluated the patient for ongoing low back pain. Examination showed markedly diminished lumbar ROM and back and leg pain with straight leg raise (SLR) bilaterally. The patient had global weakness throughout both lower extremities. reviewed the previous MRI findings and diagnosed probable herniated nucleus pulposus (HNP). He refilled medications, recommended trying a dorsal column stimulator (DCS) and obtaining MRI with and without contrast or a CT myelogram of the lumbar spine.

Per utilization review dated October 26, 2012, the request for CT myelogram of the lumbar spine was approved.

On November 2, 2012, lumbar myelogram and post myelogram lumbar CT showed: (1) Moderately severe right L5-S1 neural foraminal encroachment secondary to a right foraminal disc-osteophyte complex which impinged on the exiting right L5 nerve root sheath. (2) Prominent dorsal annular disc bulge measuring 6 mm in anteroposterior dimension at the L4-L5 level superimposed on mild dorsal osteophytes. The neural foramina at L4-L5 appeared mildly encroached. The lateral recesses were narrowed and the central canal was borderline stenotic. (3) Neural foramina at L2-L3 and L3-L4 were only subtly encroached secondary to subtle annular disc bulging. (4) There was minimal levoconvex curvature of the lumbar spine.

On December 11, 2012, evaluated the patient for intermittent lumbar pain radiating to both the thighs and the right hip area. Examination of the lumbar spine showed tenderness, painful and decreased ROM, some paresthesias along the right L4 distribution, blunted reflexes throughout symmetrically and back and leg pain with SLR bilaterally. The patient had tenderness and global weakness in both lower extremities. reviewed the CT myelogram findings and surgical report of October 1996 that documented significant calcification of L4-L5 disc. The CT myelogram showed a moderate foraminal stenosis at L5-S1 and there was significant residual stenosis at L4-L5 with obvious calcification of L4-L5 annulus. diagnosed HNP, L4-L5 and L5-S1 with stenosis and residual neurogenic claudication and recommended revision discectomy, decompression and foraminotomy.

Per utilization review dated January 10, 2013, the request for lumbar laminectomy revision at L4-L5 and L5-S1 was denied based on the following rationale: *"The request for lumbar laminectomy revision at L4-L5 and L5-S1 is not supported by the submitted clinical information. The available data indicates that the claimant sustained an injury to his back which resulted in performance of laminectomy and foraminotomy at L4-L5 and L5-S1 performed on October 24, 1996. The record provides absolutely no data regarding interval treatment. There is no indication that the claimant has recently undergone any physical therapy or been evaluated for possible epidural steroid injections based upon his complaints. The claimant has previously undergone MRI of the lumbar spine which notes evidence of a disc herniation at the L5-S1 level with contact involving the exiting nerve roots. More recently, a CT myelogram notes that there is some evidence of neural foraminal stenosis; however, there is no central canal stenosis identified on the imaging*

report. It is opined that the claimant has neurogenic claudication. However, the record does not include any detailed examination records which would establish the diagnosis of neurogenic claudication. There are no subjective complaints of worsening pain with walking or relief with sitting. The claimant was noted to have a residual radiculopathy after his prior surgery. Therefore, given the lack of documentation of recent conservative care and noting the lack of symptoms attributable to neurogenic claudication, the request cannot be supported as medically necessary at this time. Attempts have been made to reach the provider but were unsuccessful.”

Per reconsideration review dated February 1, 2013, the appeal for lumbar laminectomy revision at L4-L5 and L5-S1 was denied based on the following rationale: *“The patient has a remote injury in 1993. The patient has a history of surgical intervention both at the L4-L5 and L5-S1 level for decompressive surgery. The most recent object of studies to include a CT myelogram from December 2012 suggests the patient has moderate foraminal and central spinal stenosis, mostly right sided. The most recent notes reviewed from 2012 October through December - no diffuse global weakness in the lower extremities and nothing focal. Why decompressive surgery is recommended now without focal findings or evidence of a cauda equine syndrome is not delineated. In brief, the patient has little or no clinical correlation other than back pain to warrant this request for repeat surgical intervention. No attempted of recent non-operative therapy to include injection therapies have been trialed. The applied diagnosis of spinal stenosis is not applicable nor is it established. Peer to peer was not successful.”*

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

I have had the opportunity to review the extensive forwarded records on this patient which dated back to 1993.

The DWC-1 indicated that the patient stepped on a pipe while trying to retrieve his jacket and fell backwards with injury to his back. The records throughout 1993 and 1994 are sparse; however, the patient did have an evaluation which noted that the patient had discomfort in the neck as well as low back. He was diagnosed with mechanical spine injury with neck and low back pain. A CT scan was ordered.

The CT scan on February 21, 1994, showed no evidence of disc bulging or herniation at L4-L5 and there was minimal bulging noted at L5-S1 without evidence of impingement upon the neural elements. The patient did have formal therapy performed in the 1994 timeframe.

The patient's care then came under orthopedic surgeon, for resolving lumbosacral strain. Many of the records are handwritten and are only partially legible.

The patient did have an impairment assessment performed on October 6, 1994, and he awarded the patient a 5% impairment rating. He felt the patient could go

back to work at light duty on a full-time basis. However, continued to provide multiple medications for this patient and also continued to keep him off work.

The patient was noted on November 27, 1995, that there was low back pain with radiation to the right thigh. In 1996, diagnosed a herniated disc at L4-L5 and L5-S1

on July 10, 1996, noted the patient's clinical course and that there had been an MRI completed on December 28, 1995. He reported symptoms of pain to the right leg and also that the patient had had some difficulty with retention of urine but that had resolved with change of medications. The patient reported a walking tolerance of less than one block.

On September 27, 1996, performed a required medical examination and placed the patient at statutory MMI with a 9% impairment rating.

The patient continued to be followed and was provided access to multiple medications including Vicodin, Norflex as well as Anaprox.

On October 24, 1996, performed a laminotomy and discectomy at L5-S1 but only a decompression of the shell that was calcified over the annulus at L4-L5. He did not enter the disc space by his own operative report.

On subsequent follow-up visits with, multiple medications were continued to be prescribed essentially with office visits on a monthly basis.

On September 3, 1998, did a medical evaluation and noted that the patient was at MMI and that the patient had exaggerated pain symptoms. Overall, the neurological exam was normal. However, disagreed with opinions and continued to provide the patient with multiple medications including Motrin, Tylenol and Soma but also access to Vicodin and Viagra.

On April 27, 1999, electrodiagnostic study was performed noting nerve root irritation at L4-L5 but this was on the left side, not the work injury reported right side.

on August 27, 2001, performed a peer review. He proposed that the long-term use of narcotics did not meet guideline criteria. Moreover, Soma and codeine should not be utilized together.

The patient did have access also as documented to a TENS unit for pain control. However, its effectiveness is not discussed.

On June 27, 2003, the patient apparently slipped and fell in his kitchen. Of interest this slip and fall did not cause a new injury or an aggravation of his old injury.

On January 16, 2004, took over the care for the patient due to death. The neurological exam was normal.

then continues to follow the patient and provides not only access to Tylenol with Codeine but also Vicodin ES, Soma and Motrin. She also provided essentially monthly office visits.

performed a medical records review on December 7, 2005. He noted that the patient would only need two or three office visits per year. He was on a maintenance type of regimen medically. Diagnostic testing would only be necessary for medication use. There was no indication for further physical therapy. He proposed that the patient be transitioned to Ultram.

On February 27, 2006, noted that the patient had a chronic pain syndrome and failed back surgery syndrome and that the patient would warrant flexion-extension views. He also gave a prescription for Lorcet as well as the lumbar brace.

On follow-up visit, he opined that the patient's narcotic regimen was not warranted and should be addressed with a chronic pain management program.

The patient then comes under the care of who continues to be a source of medication refills for Vicodin and Soma, until he stated that he would no longer write further Vicodin in the early 2010 timeframe. did document that the patient had not worked since 1993 and that there had been a large skin graft over the thoracic spine apparently after an abscess that occurred in 2004.

had proposed trigger point injections which had not been approved through the pre-cert process.

On August 15, 2011, a right hip MRI was performed and was unremarkable.

On September 1, 2011, an MRI of the lumbar spine was completed showing central and right subarticular disc herniation at L5-S1 contacting the traversing right S1 nerve root with what was reported as a broad-based disc herniation at L4-L5 and a disc protrusion at L3-L4 as reported by.

The patient on February 1, 2012, was reassessed. He noted that the patient was unable to do flexion-extension of the lumbar spine. neurological assessments are inconsistent regarding the straight leg raise being positive on some and negative on some exams as well.

On May 9, 2012, noted that the pain was noted in the neck, midback and low back.

Then the patient was assessed on October 11, 2012, who noted the patient's ongoing back pain. He noted that the patient had decreased spine range of motion and had straight leg raise positive bilaterally. The patient was also noted to have global weakness throughout both lower extremities.

He noted that the previous MRI had not been done with gadolinium even though the patient had previous surgery. A myelogram CT scan was approved and completed on November 2, 2012. This study showed right neural foraminal decrease with disc osteophytes present. There was also an annular bugle at L4-L5 which resulted in mild canal narrowing. The overall assessment was that the neural foramen at L4-L5 appeared only mildly encroached and the central canal was only borderline stenotic. The L5-S1 level did have the foraminal narrowing worse on the right.

on December 11, 2012, noted the patient to have still residual back tenderness with decreased range of motion. There was report of paresthesias in an L4 distribution on the right. There was still global weakness in both lower extremities.

He stated that the surgical report documented significant calcification of the L4-L5 disc but that the current myelogram showed a moderate foraminal stenosis of L5-S1 and significant residual stenosis of L4-L5 with obvious calcification of the L4-L5 annulus. He now proposed that the patient have a revision discectomy, decompression and foraminotomy.

There were two utilization reviews who noted that there was not a significant spinal stenosis noted at L4-L5 and L5-S1. Moreover, there had been no other treatments provided for this patient's condition recently except for medication management.

The overall records do not support that this patient would warrant a two-level decompression and a surgery with discectomy. Moreover, the disc at L4-L5 was calcified which is clearly documented. The proposal that the patient has L4 paresthesias but also bilateral lower extremity global weakness is inconsistent with the imaging study. The myelogram study showed the only area of the spine that has what appears to be narrowing of significance potentially would be that of L5-S1 on the right. Thus we have a significant mismatch of the symptoms reported and the imaging findings.

This patient's records are replete with inconsistencies in the neurological exam and the symptoms reported. Moreover, there is no report of any psychological assessment of the patient's pain behavior or pain tolerance. This patient has not worked since 1993. The likelihood of any significant benefit with the proposed surgery in my opinion does not warrant any type of surgical intervention. The patient does not have established neurogenic claudication nor does he even have established specific nerve root deficit.

Thus the URA denials as documented in the records forwarded for review should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES