

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: December 23, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

COSA Outpatient Decompression Surgery with a Simple Laminectomy @L5-S1

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

The physician is a Board Certified Orthopedic Surgeon with over 13 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:

01/23/10: X-ray Lumbosacral Spine, 2 views
01/12/11: MRI Lumbar Spine interpreted by MD
01/12/11: X-ray Lumbar Spine with Flexion/Extension interpreted by MD
02/01/11: Management Consultation by MD with Management Center
02/08/11: Pain Management Follow-up Visit by PA for MD with Pain Management Center
03/02/11: Letter of Clarification by MD with Management Center
03/14/11: Operative Report by MD

03/21/11: Pain Management Follow-up Visit by PA for MD with Pain Management Center
04/28/11: Evaluation by, DO with Orthopaedic Group
05/06/11: Follow-up Evaluation by DC
05/16/11: Pain Management Follow-up Visit by PA for, MD with Pain Management Center
05/18/11: EMG/NCV of the bilateral lower extremities by, DO
06/03/11: Letter of Clarification by MD with Pain Management Center
06/06/11: Follow-up Evaluation by DC
06/14/11: Operative Report by DO
06/29/11: Follow-up Evaluation by DO
07/06/11: Follow-up Evaluation by, DC
07/29/11: Follow-up Evaluation by DO
08/05/11: Follow-up Evaluation by DC
08/19/11: Initial Office Visit by MD with Spinal Clinic
09/02/11: Follow-up Evaluation by DC
11/11/11: Follow-up Evaluation by DC
01/04/12: Follow-up Evaluation by DC
03/02/12: Follow-up Evaluation by DC
03/09/12: Follow-up Evaluation by DO
03/26/12: Follow-up Evaluation by DC
03/27/12: Comparison MRI Examination of the Lumbar Spine interpreted by MD
04/09/12: Follow-up Evaluation by Brad Burdin, DC
04/26/12: Lumbar Myelogram
04/26/12: Post myelogram CT of the Lumbar Spine interpreted by, MD (and Addendum)
05/07/12: Follow-up Evaluation by DC
06/01/12: Follow-up Evaluation by MD
06/06/12: Follow-up Evaluation by DC
07/06/12: Follow-up Evaluation by DC
09/10/12: Letter by, DC
10/25/12: Decision and Order
11/14/12: UR performed by MD
11/27/12: UR performed by MD

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was employed by the, when on xx/xx/xx he was moving a patient that weighed 305 pounds within the ambulance bed. He was standing on the bumper of the ambulance and had to lift at a chest level. When he went to transfer the patient to the right he felt the left side of his back give way and an intense pressure on the right side of his low back. He came under chiropractic care by Dr. and received no pharmacotherapeutics until 02/01/11.

On January 23, 2010, prior to injury, X-ray of the lumbosacral spine, Impression: No acute fracture or subluxation is identified. Degenerative disc space narrowing is present at L3-L4 and L4-L5. Vertebral body heights are maintained. The paravertebral soft tissues are unremarkable.

On January 12, 2011, MRI of the Lumbosacral Spine, Impression: Very minimal degenerative disc disease along the lumbosacral spine with mild facet arthropathy primarily involving the right L4-L5 facet with a small facet joint effusion and mild osteophytic spurring but no significant reactive bone marrow edema.

On January 12, 2011, X-ray of the lumbosacral spine, Impression: Normal radiographic examination of the lumbosacral spine.

On February 1, 2011, the claimant was evaluated by, MD at the request of DC for low back pain. Current medications were listed as none. It was reported he smokes half a pack of cigarettes a day for the past 16 years. On physical examination he had full range of motion of the lumbar spine with no midline tenderness. He did have tenderness to palpation over lumbar facets at L4-L5 and L5-S1 bilaterally, right greater than left. Straight leg raise test was negative bilaterally. He had decreased sensation to pinwheel on the S1 dermatome of the left lower extremity compared to the right. Motor strength was 5/5 and deep tendon reflexes were 2+. Impression: 1. Bilateral L5 radiculopathy. 2. Lumbar facet arthropathy. 3. Right L4-L5 facet effusion. 4. Low back pain since date of accident. Plan: Prescription for Prednisone 5 mg, Soma 350 mg, and Fioricet.

On February 8, 2011, the claimant was re-evaluated by MD who reported the Prednisone helped, but the Soma gave him headaches. The claimant reported he had several occasions of tingling and numbness down both thighs that ended at the knee level. On exam reported equal sensation to pinwheel bilaterally, motor strength was 5/5, and deep tendon reflexes were 1+ at the knee. Straight leg raise was positive bilaterally in the L5 distribution. Recommendation: Intralaminar lumbar epidural steroid injection.

On March 14, 2011, Operative Report by MD. Postoperative Diagnosis: 1. Bilateral L5 radiculopathy. 2. Lumbar facet arthropathy/syndrome. 3. Right L4-5 facet effusion. 4. Low back pain since the date of accident. Procedures: 1. Lumbar epidural steroid injection. 2. Fluoroscopic guidance of the needle. 3. Lumbar epidurogram and interpretation of the epidurogram. 4. Injection of substance into the spinal canal for anesthesia purposes. 5. IV conscious sedation. 6. Coverage and observation for 24-hours post-procedurally.

On March 21, 2012, the claimant was re-evaluated by Dr. who reported he responded well to the first lumbar epidural steroid injection and was now only complaining of intermittent pain and no radicular symptoms. He was prescribed Naproxen 500 to continue the anti-inflammatory effect of the steroid. It was also noted he was to begin a work-hardening program with Dr..

On April 28, 2011, the claimant was evaluated by, DO who on physical examination found sharp pain in the lumbosacral junction with extension of the lumbar spine. No SI joint tenderness or greater trochanteric tenderness. He could forward flex to his toes. He had 5/5 strength in ankle dorsiflexor, plantar

flexors, knee flexors and extensors, hip flexors and extensors, hip abductors and adductors bilaterally. He had 2+ knee and ankle jerks bilaterally. He had normal sensation and no atrophy of the lower limbs. Straight leg raise induced low back pain at 70 degrees bilaterally. Assessment: Axial back pain, possible facet joint, could be referred symptoms or could be possible lumbar nerve root irritation; however, he has these lower limb symptoms. Plan: EMG/NCV. If negative, consider Medial branch blocks bilateral lateral L4-L5 and L5-S1. Prescribed Voltaren 75 mg, Neurontin 300 mg, and Nucynta 75 mg.

On May 16, 2011, the claimant was re-evaluated by MD who reported he had a progressive return of his low back pain with radicular symptoms. A repeat intralaminar lumbar epidural steroid injection was recommended.

On May 18, 2011, the claimant underwent an EMG/NCV performed by DO. EMG of the bilateral lower extremities was normal. NCS of the lower extremities was also normal. Overall there was no evidence of bilateral lumbar radiculopathy or lumbar plexopathy or peripheral neuropathy.

On June 14, 2011, Operative Report by DO. Postoperative Diagnosis: Low back pain. Procedures: 1. Bilateral L4-5 and L5-S1 medial branch blocks. 2. Fluoroscopic guidance.

On June 29, 2011, the claimant was re-evaluated by DO who reported he was still having pain particularly in his low back. Plan: Surgical evaluation and possible provocative discography.

On August 19, 2011, the claimant was evaluated by MD for lumbar back pain and left leg pain. On physical examination he had left posterior iliac spine and left sciatic notch tenderness. Forward flexion was to 80 degrees with mild dysrhythmia. Leg lengths were equal with symmetric circumference. Motor strength was 5+/5+. He had decreased L5 sensation on the left side. He had 1+ symmetric reflexes. He had left sided straight leg raise to 45 degrees; negative clonus. He had fair toe/heel walk. He had full range of motion of the hips. Impression: Lumbar radiculopathy, rule out L5-S1 root compression. Recommendations: Lumbar myelogram CT scan for more definitive evaluation of root compression.

On March 9, 2012, the claimant was re-evaluated by DO who reported he was still having pain down the left leg. There were issues regarding compensability. His physical examination was unchanged. Plan: CT-myelogram and prescription for Percocet, Neurontin, and Voltaren.

March 27, 2012, Comparison to MRI Examinations of the Lumbar Spine was completed by, MD. The first MRI was performed at Medical Group dated xx/xx/xx (prior to the date of injury). The second was performed at Imaging Center on January 12, 2011. Impression: Both studies show L4-L5 pars fractures. The

second study shows new elongation of the L5 pars consistent with interval displacement.

April 2, 2012, Lumbar Spine, Comparison to Radiographic Series was completed by MD. Impression: Both studies show L4 and L5 pars fractures. Apparent new 3 mm anterior displacement of the L5 pars fracture on the second study.

On April 9, 2012, the claimant was re-evaluated by DC who reported he had a decreased perception of vibration in the left lateral leg compared to the right and a slight decrease in his perception of vibration in the left medial leg compared to the right. Reflexes were 2+ and sluggish and almost 1+ in the lower extremities. Lower extremity strength grades were 5+. Lumbar rotary extension procedures were painful bilaterally. Lumbar flexion was 70 degrees without any significant pain, but extension was less than 5 degrees and was quite painful bilaterally. It was reported that in January of 2010, the claimant had a prior injury when he had a patient in the back of an ambulance who was boarded down when the driver took a hard turn causing the claimant to almost fall on his patient. In an effort to stop from falling on the patient, he jumped over him and said that he very firmly hit the back of a shelf with his lower back.

On April 26, 2012, Lumbar Myelogram, Impression: Suggestion of minimal anterior extradural impression on the thecal sac at L4-L5 which may relate to slight bulging of the disc. See the CT scan report for complete description. No evidence of a focal disc herniation or substantial spinal stenosis at any of the other levels is present.

On April 26, 2012, Postmyelogram CT of the Lumbar Spine, Impression: 2. Central disc protrusion at L5-S1 with abutment of the thecal sac but no compression of either L5 or S1 nerve root. Addendum: I have been asked to review the postmyelogram CT appearance at L5-S1. The central disc herniation produces 3 mm of midline compression on the thecal sac. Both S1 root sleeves fill with contrast. Sagittal image 31 shows abutment of the right S1 nerve root in the lateral recess. No displacement or compression of the left S1 nerve root. I am only reviewing the postmyelogram CT and did not have the Myelographic images. It is possible that the myelogram images with weight-bearing show greater degree of nerve root compression in the postmyelogram CY obtained with patient supine.

On June 1, 2012, the claimant was re-evaluated by MD for continued back pain which radiates to his left buttock, posterior leg to his lateral ankle. On physical exam he revealed left sciatic notch tenderness. He had decreased L5 sensation. He had left sided straight leg raise to 30 degrees. He had intact motor strength and reflexes were symmetric; no atrophy. Dr. assessed that the claimant was symptomatic from an L5-S1 HNP and has left sided radiculopathy. He had not had any significant improvement with all conservative treatment measures to date. Dr. wished to proceed with an outpatient decompression at the L5-S1 level with a simple laminectomy.

On July 6, 2012, the claimant was re-evaluated by DC who reported that compensability issues remained. On physical examination he had decreased perception of vibration, which was obvious in the left lateral leg compared to the right. Reflexes were 1+ in the left patella and Achilles reflexes. The patellar reflex required Jendrassik's maneuver. His left EHL graded as 4/5 and the right was also weak, but had more strength than the left. Lumbar rotary extension procedures were painful bilaterally and he had some spasm on palpation. Lumbar flexion did not cause increased pain. Dr. recommended flexion and extension films to make sure that there was not any translation occurring.

On October 25, 2012 a Decision and Order by the Texas Department of Insurance, Findings of Fact: 4. Dr. determined that the compensable injury included the L4-L5 and L5-S1 disc bulges but did not include an L5 pars fracture or facet arthropathy. 6. The evidence is insufficient to establish that Claimant suffers from an L5 pars fracture or that the claimed L5 pars fracture was caused or aggravated by the December 23, 2010 compensable injury. Decision: The compensable injury of December 23, 2010 does not extend to and include an L5 pars fracture and facet arthropathy but does extend to and include L4-L5 and L5-S1 disc bulges.

On November 14, 2012, MD performed a UR. Rationale for Denial: The requested decompression surgery with simple laminectomy at L5-S1 is not recommended as medically necessary. Per the CT myelogram addendum report, there was evidence of a right S1 nerve abutment secondary to a 3 mm disc protrusion. The addendum indicated there was no displacement or compression of the left S1 nerve root. The 06/12 exam findings suggested a left-sided radiculopathy that was not consistent with the imaging reports. Additionally, there is no evidence of any significant canal stenosis at L5-S1 that would reasonably benefit from the requested simple laminectomy. Given the patient's inconsistent findings on physical examination and lack of evidence of significant spinal canal stenosis, the requested surgical procedures are not supported as medically necessary. As the surgical request is not indicated at this time, a postoperative summit brace would not be needed or warranted at this time.

On November 27, 2012, , MD performed a UR. Rationale for Denial: The requested L5-S1 laminectomy is not recommended as medically necessary based on the clinical documentation provided for review and current evidence based guidelines and MRI studies and CT myelogram studies showed evidence of abutment in the right S1 nerve root, however, the last physical examination in 06/12 revealed left sided symptoms. There was no evidence of significant canal stenosis that would reasonably benefit from laminectomy procedures. Additionally, no updated clinical evaluation after 06/12 was provided for review to support the surgical request. Given the limited objective evidence of consistent radicular findings on physical examination and without an updated physical examination, medical necessity would not be established at this time.

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

The previous adverse determinations are upheld. Laminectomy at L5-S1 is not an appropriate surgery for this claimant. The purpose of a lumbar laminectomy procedure is to decompress central canal stenosis. The MRI of January 12, 2011 documented no central stenosis. The postmyelogram CT of April 26, 2012 also did not document any central stenosis. This CT study did not explain the claimant's left leg symptoms. The EMG/NC study of May 18, 2011 documented no evidence of radiculopathy. It is unclear whether the claimant has objective findings of radiculopathy, as his examination is inconsistent in the medical record.

The pain generator for the claimant's symptoms has not been identified. The claimant's primary complaints are back pain and left leg pain. The laminectomy will not address the back pain issues associated with two level lumbar disc disease and a pars fracture. Until this pain generator is identified, it would not be appropriate to move forward with laminectomy at L5-S1. The request for COSA Outpatient Decompression Surgery with a Simple Laminectomy @L5-S1 does not meet ODG criteria, therefore, it 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)**