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Notice of Independent Review Decision

January 4, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Discectomy at L4-L5 left with one-day patient stay.

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

Board Certified Orthopedic Surgeon

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.

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:

Healthcare

- Diagnostics (03/16/11, 12/05/11, 03/26/12)
- Office visits (04/25/11 - 10/30/12)
- Work conditioning (06/20/11 – 07/21/11)
- Utilization reviews (10/12/12, 12/04/12)

TDI

- Utilization reviews (10/12/12, 12/04/12)

D.C.

- FCE (03/03/11)
- Diagnostics (03/16/11, 03/26/12)
- Reviews (07/18/11, 01/12/12)
- Office visits (10/19/11 - 12/04/12)

M.D.

- Diagnostics (03/16/11, 12/05/11, 03/26/12)
- Office visits (04/25/11 - 10/30/12)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was mounting eight tires for a unit when one of the bars slipped, making his body twist to the left/counter-clockwise and he heard his lower back pop.

On March 3, 2011, the patient is attended a functional capacity evaluation (FCE). It was noted that the patient was first seen at Concentra where x-rays were taken and he was prescribed medications. Then the patient was evaluated at the Health Centers on February 22, 2011, where x-rays were taken and the patient was referred to Dr. who prescribed medications. The patient continued with Health Centers where he underwent physical therapy (PT) and a magnetic resonance imaging (MRI) of the low back had been ordered. The evaluator noted deficits during the evaluation. The patient was limited with regard to functional tolerance levels and range of motion (ROM) in the affected areas and should begin with a gradual increase in condition to minimize chances of exacerbation or re-injury. The evaluator recommended an active therapeutic exercise program.

On March 16, 2011, MRI of the lumbar spine showed: (1) Left paramedian 6-mm disc protrusion at L4-L5 with disc material abutting descending left L5 nerve root in the lateral recess, mild disc signal and height loss at L4-L5 with mild broad-based posterior disc bulge and mild left neural foraminal narrowing at L4-L5 secondary to disc bulge and facet joint hypertrophic changes with disc material abutting the inferior aspect of the exiting left L4 nerve root.

On April 25, 2011, M.D., evaluated the patient for low back pain radiating once in a while to the right lower extremity. Examination of the lumbar spine and leg showed limited back motion and tenderness in the lumbosacral spine region, positive leg raise on the right side at about 45 degrees and sciatic irritation on the right side. Neurological examination showed that the patient had complaints of low back pain and great difficulty in bending and reaching for his knees and severe pain in the lumbar region and tenderness about the level of L4-L5 muscle on the right side. Dr. reviewed the MRI findings and diagnosed L4-L5 herniated disc. He recommended spinal epidural block followed by therapy under Dr.. If the

PT and injections did not help, then the patient should be treated surgically most likely laminectomy and discectomy at L4-L5. Dr. prescribed hydrocodone and recommended epidural steroid injection (ESI) of the lumbar spine.

From June 20, 2011, through July 21, 2011, the patient attended 17 sessions of work conditioning program (WCP).

On July 18, 2011, M.D., performed a medical evaluation. Following additional records were noted: On February 10, 2011, PA, evaluated the patient for low back pain. X-rays were unremarkable. Mr diagnosed lumbar strain on the left, administered injection Toradol, and prescribed naproxen, Skelaxin, acetaminophen/hydrocodone. He dispensed ice/cold pack and Biofreeze and placed the patient on modified activity.

On February 15, 2011, the patient underwent initial PT evaluation at and he was recommended PT three times a week for two weeks.

On May 2, 2011, D.C., noted the patient's medical condition had prevented him from returning to work as of May 2, 2011, and the patient was expected to continue to do so through May 9, 2011. ESIs were pending.

On July 20, 2011, the patient attended work conditioning/work hardening home program.

On August 13, 2011, D.C., evaluated the patient for low back pain. Examination of the lumbar spine showed inflammation and tenderness at the lateral portion on the left side of the lumbar spine and restricted ROM. Straight leg raise (SLR) was positive on the left. Lasegue's test was positive and the patient's radicular pain was exacerbated upon passive dorsiflexion on the left. Dr. recommended 16 sessions of WCP, electromyography (EMG) and referred the patient to Dr. .

On October 19, 2011, Dr. evaluated the patient for low back pain radiating down to the buttocks and posterior aspect of the right leg and left leg but worse on the right side. The patient reported tingling and numbness sensation in the legs but right worse than left. Dr. noted that the patient was currently pending for work hardening program (WHP). He referred the patient to Dr. for further treatment and evaluation.

On December 5, 2011, MRI of the lumbar spine without contrast showed: (1) Transitional anatomy with partial sacralization of L5. (2) Multilevel lower lumbar spondylotic changes. (3) At L4-L5, a broad central disc protrusion with moderate spinal canal stenosis and moderate bilateral foraminal narrowing. (4) At L3-L4, mild disc bulge with mild spinal canal stenosis.

On December 8, 2011, Dr. evaluated the patient for low back pain radiating into the buttocks and legs. He recommended applying Biofreeze to two to three times a day to the tender areas and referred the patient to Dr..

2012: On January 12, 2012, M.D., performed a medical evaluation. The medical records contain the following additional information:

On October 6, 2011, Dr. performed a designated doctor evaluation (DDE). The patient's diagnosis was L4-L5 paramedian with slight right lateralization of L4-L5 disc of 6 mm which was supported by objective findings based on positive SLR which was consistent with both supine and seated and also by the MRI. The patient's prognosis was guarded because he had lot of pain and was progressively getting worse and it was progressively becoming more frequently radicular in nature. Chiropractic visits would not be medically necessary or reasonable. The patient had attended nine session of PT which were within the parameters of ODG. The treatment ordered by a chiropractor consisting of three computer muscle testing and ROM was inappropriate based on clinical evaluation. The foot scan which had been performed was not necessary. Presently ESIs should be recommended. However, a series of three ESIs were not medically necessary or reasonable. Prescription medications that the patient was getting were medically necessary to control the pain. If ESIs were unsuccessful then a very thorough history and physical examination should be carried out and should be performed by either an orthopedic spine surgeon or a neurosurgeon for a probable decompression at L4-L5.

On October 11, 2011, Dr. Suttle performed a DDE and opined that the patient had not reached maximum medical improvement (MMI) as he was showing signs of radiculopathy with ongoing positive SLR test bilaterally. Further evaluation by an orthopedic surgeon was appropriate presently.

Dr. opined as follow: (1) The patient had not reached MMI. If he had surgery at the L4-L5 level without fusion, he should be at MMI approximately three to four months after that surgery. The patient would only be able to perform light physical demand level (PDL) job duties. An FCE had been requested.

On March 8, 2012, M.D., noted that the patient's back pain was controlled with medications but after work, the patient had a very acute pain. The patient was still working light duty. The patient was utilizing ibuprofen, Tylenol, Lyrica, Norco and tramadol. Dr. diagnosed sprain and strains of other and unspecified parts of the back, prescribed Norco, discontinued Tylenol and recommended urine drug screen.

On March 19, 2012, M.D., evaluated the patient for low back and bilateral lower extremity pain. The patient was status post bilateral L4-L5 transforaminal ESI that was performed on March 2, 2012. Dr. noted that the urine drug screen performed on February 28, 2012, was positive for tramadol. Dr. diagnosed lumbar pain, lumbar radiculitis, lumbar spinal stenosis, lumbar disc displacement, chronic intractable pain and long-term use of medications and prescribed Norco and ibuprofen. The report is illegible.

On March 25, 2012, M.D., evaluated the patient for low back pain radiating to the right leg. The patient complained of numbness and tingling and sometimes weakness and he had been unable to return to regular duty. Dr. performed

electromyography/nerve conduction velocity (EMG/NCV) of the lower extremities that showed no evidence of radiculopathy either acute or chronic.

On March 29, 2012, Dr. recommended application of Biofreeze on tender areas. He referred the patient to Dr. for further evaluation and treatment.

On April 25, 2012, Dr. evaluated the patient for low back pain, bilateral lower extremity pain and chronic intractable pain syndrome. Dr. reviewed the EMG findings and refilled Gralise, Norco and tizanidine.

From June 19, 2012, through August 8, 2012, Dr. treated the patient with Biofreeze application to the tender areas and referred the patient to Dr.

On October 4, 2012, Dr. noted that the patient had severe pain in the lumbosacral spine region. The patient had positive leg raising sign on the right side, 6 mm paramedian herniated disc on the left side, great difficulty in bending, stooping, squatting and difficulty on walking on heels and toes mainly on the left side. The patient reached above the knee and complaints of severe spasm in the lumbosacral region and the pain radiated to the left lower extremity all the way down to the calf and sometimes to the heel. The patient desired to have a surgery presently. Dr. prescribed Vicodin and opined that the patient was a good candidate for surgical intervention. He requested surgery for the patient including laminectomy and discectomy at L4-L5 on the left.

On October 10, 2012, Dr. refilled medications and referred the patient to Dr..

Per the utilization review dated October 12, 2012, the request for lumbar laminectomy and discectomy at L4-L5 on the left was denied based on the following rationale: *"This request is for a lumbar laminectomy and discectomy at L4-L5 on the left. The clinical exam of October 4, 2012, indicates that he had a positive SLR on the right and has difficulty walking on heels and toes mainly on the left side. He has sciatic irritation on the left side. He states his pain radiates to the left all the way down to the calf. However, reflexes are present and equal and there are no pathological reflexes noted and there is no muscle atrophy and apparently no sensation loss. As such, radiculopathy has not been established on physical exam. Additionally, radiculopathy was not established on the electrodiagnostic study of March 26, 2012. Furthermore, the records discuss ESIs but no injection notes were provided to identify the level of the injection given or its overall efficacy. No PT notes were provided to document the scope, breadth, or efficacy of PT. As such, the records do not objectively identify conservative care being given to this patient. Guidelines indicate that surgery may be considered reasonable and necessary if there is radiculopathy with documentation of muscle weakness or atrophy in the appropriate pattern and consistent with imaging studies and documentation of the conservative care. Therefore, the request for lumbar laminectomy and discectomy at L4-L5 on the left with a one-day inpatient stay is not considered medical necessary and is non-certified."*

On October 30, 2012, Dr noted the patient had difficulty in bending. Examination showed rotation of the back aggravated the pain, positive leg raising sign on the left with radicular pain to the lower extremities mostly to the left side, reduction of both knee and Achilles jerks and reduced pinprick sensation in the left side. Dr. recommended surgical intervention including lumbar laminectomy and discectomy at the L5-S1 level on the left with decompression of the S1 nerve root.

On October 30, 2012, Dr. evaluated the patient for ongoing complaints of low back pain. The patient reported lumbar spine pain was constant and moderate with medications, described his pain like a pressure sensation. The pain was exacerbated by physical activity, cold temperatures, daily life activities, prolonged driving, prolonged sitting, prolonged walking and prolonged standing. The patient's gait was abnormal. The patient had been undergoing physical medicine rehabilitation and doing exercises at home. Examination showed inflammation and tenderness at the lateral portion of the left side of the lumbar spine, restricted lumbar ROM, muscle strength testing at 4 of the left iliopsoas muscle and 3 of the left quadriceps muscle, positive SLR on the left and positive Lasegue's test. The patient's radicular pain was exacerbated upon passive dorsiflexion on the left side. Dr. recommended application of Biofreeze on the tender areas and referred the patient to Dr.. The patient was pending lumbar spine surgery by Dr..

On November 6, 2012, Dr. noted the surgery had been denied. The patient had low back pain ranging between 6/10 and 7/10 and worse with activities. Dr. refilled medications and recommended follow-up with Dr..

Per the reconsideration review dated December 4, 2012, the appeal for lumbar laminectomy and discectomy at L4-L5 on the left and one-day inpatient stay was non-certified based on the following rationale: *"The clinical documentation submitted for review lacks evidence of significant objective findings upon physical exam of the patient to support surgical interventions at this point in the patient's treatment. As evidenced in the previous peer review, the patient presented with no pathological reflexes, no muscle atrophy and no sensory deficits upon physical exam. Furthermore, the clinical note dated October 30, 2012, reported the patient underwent electrodiagnostic studies of the bilateral lower extremities which revealed no abnormalities. Additionally, upon the patient's initial presentation the patient had moderate complaints of pain to the right lower extremity and on recent notes the patient presents with complaints of pain to the left lower extremity. As documented in the previous adverse determination, the clinical notes do not support the patient has an objective diagnosis of radiculopathy with documentation of muscle weakness or atrophy. Furthermore, as the clinical notes indicate the patient has utilized conservative measures; however, the patient's response to these interventions was not documented, to include ESI and PT interventions. Given all the above the request for appeal lumbar laminectomy and discectomy at L4-L5 and one day inpatient stay is non-certified."*

On December 4, 2012, Dr. noted the appeal for reconsideration of the surgery had been denied. The patient had low back pain with pain intensity ranging between 6/10 and 8/10. Dr. gave prescription for Lyrica, Norco, ketoprofen and omeprazole and recommended follow-up with Dr. and returning in one month.

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

The requested left L4-5 discectomy cannot be recommended as medically necessary based on the information reviewed.

The records suggest a varied history which has included lower back pain, lower back pain with right and/or left lower extremity pain. The patient has not had consistent symptoms radiating to either the left L4 or left L5 nerve distribution. The patient has not shown consistent objective evidence of L4 or L5 radiculopathy on examination. In addition, the patient had negative electrodiagnostic testing.

Accordingly, the patient does not meet Official Disability Guidelines, which require objective findings on exam or electrodiagnostic studies to correlate with neural compressive pathology on an MRI.

Though the patient has pathology on the MRI, it is not clear that this correlates with the varied symptoms and exam findings noted within the records reviewed.

IRO REVIEWER REPORT TEMPLATE -WC

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES