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Notice of Independent Review Decision

June 20, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Surgical decompression at L3-L4 and L4-L5 using microdiscectomy, right-sided approach (63030, 63035)

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:

TDI

- Utilization reviews (01/23/13, 05/16/13)
- Diagnostic (12/26/12)
- Diagnostic (12/26/12)
- Office visits (11/13/12 – 01/08/13)
- Therapy (12/04/12 – 01/08/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is male who on xx/xx/xx, was taking a water heater down off a platform about five feet high. He thought it was empty, but it still had a bunch of slug in it. When they slid it off the platform, it immediately took them to the ground. The patient injured his lower back, arch, around into the stomach area and into the legs.

On November 13, 2012, evaluated the patient for back pain. The patient's pain drawing depicted pain in the low back and bilateral thighs, rated as 8/10. The patient reported that his symptoms had worsened since the injury. He was not receiving any treatment. The pain limited his activity to include working, having fun and having sex. The activities that increased his pain included sitting, standing, walking, working, driving, sleeping and lifting. Activities that decreased the pain included lying down and taking medications. It was noted that the patient smoked two packs of cigarettes per day for thirty years and consumed two caffeine-containing beverages per day. Examination showed absent dorsalis pedis and posterior tibial pulse bilaterally. reviewed the imaging studies including lumbar spine films which showed a rudimentary twelfth rib, preserved lumbar lordotic curve, osteophytes at L3-L4, L4-L5 and calcification of the vasculature anterior to L3 and L4. It was more severe at the bifurcation. There was narrowing of L5-S1 again with calcification in the vasculature. Oblique films showed intact pars intraarticularis throughout the lumbar spine bilaterally. Flexion/extension views failed to reveal any evidence of axial or translational instability. Diagnostic impressions were tobacco dependence, disc disruption probably at L4-L5, but possibly both L4-L5 and L5-S1 and absence of pulses in both lower extremities. prescribed a longer acting anti-inflammatory, Tramadol for pain and physical therapy (PT). He advised the patient about the findings regarding his circulation and felt that his primary care doctor should have been made aware of this. The patient was encouraged to become a nonsmoker immediately. He was placed off work as no light duty was available.

On December 4, 2012, the patient underwent evaluation at The. He was treated with electrical stimulation and was recommended 12 sessions of PT and a baseline functional capacity evaluation (FCE).

In an FCE dated December 10, 2012, the evaluator noted that the patient was not strong enough to return to work and had pain with most activities. The patient was recommended completing PT and re-evaluation.

On December 18, 2012, the patient indicated that since the injury back in, his pain had been persistent. PT and medications including pain medications and anti-inflammatories had not helped. assessed persistent low back pain with right buttock and right thigh pain and recommended magnetic resonance imaging (MRI) of the lumbar spine.

On December 26, 2012, MRI of the lumbar spine showed the following findings: (1) A disc bulge at L5-S1. (2) At L4-L5, there was a broad-based disc herniation, superimposed bulge and mild-to-moderate bilateral foraminal stenosis and contribution from hypertrophic facet disease. (2) At L3-L4, there was a disc bulge

and superimposed far right paracentral disc herniation. There was moderate right and mild left foraminal stenosis and contribution from hypertrophic facet disease. (3) There was a shallow disc bulge at L1-L2.

On January 8, 2013, reviewed the MRI of the lumbar spine which showed what appeared to be disc herniation at L3-L4 on the right side; on the L4-L5 level, there was a protrusion extending from side to side. At L4-L5, both foramina appeared to be compromised and there was also facet hypertrophy. At L3-L4, there was some facet hypertrophy, but the main problem appeared to be a fairly large disc herniation which compromised both foramina, more on the right than left. assessed L3-L4 and L4-L5 disc herniations, most severe at L4-L5 but L3-L4 was also a significant factor. The patient reported that he previously had a round of injections, but they were only temporarily helpful and this problem had persisted to the point where it was now making it impossible for him to do his job. recommended surgical decompression at L3-L4 and L4-L5 using the microdiscectomy, right sided approach.

On January 8, 2013, the patient underwent therapy re-evaluation. It was noted that the patient had undergone 12 sessions of PT consisting of heat, therapeutic exercises for core stabilization and home exercise program (HEP).

Per utilization review dated January 23, 2013, the request for surgical decompression at L3-L4 and L4-L5 using microdiscectomy, right-sided approach was denied, with the following rationale: *“Based on the records provided, the claimant is a male who reports a vocational injury on xx/xx/xx. The claimant was taking a water heater off a platform five feet high and he works as plumber. The claimant has a past medical history of tobacco dependency. The claimant has herniations at L3-L4 and L4-L5 and absent pulses in both lower extremities. The subjective complaints include back pain and thigh pain. It was noted on December 18, 2012, the claimant was treated with physical therapy, medications, and anti-inflammatories and wanted to get better and return to work. The examination findings noted absent pulses bilaterally and recommended smoking cessation, anti-inflammatories and off work. The MRI dated December 26, 2012, showed degenerative disc disease at L4-L5, L3-L4 and L5-S1. There was a disc bulge with superimposed far right paracentral disc with moderate foraminal stenosis. There was also stenosis and a broad-based disc at L4-L5 with moderate foraminal stenosis. I did have the opportunity to discuss this case with. In this case, it appears appropriate conservative measures were rendered thus far to include activity modification, physical therapy and pain medications. I inquired about epidural steroid injections. They state the claimant had deferred. I inquired about smoking history as the claimant is a smoker and had absent pulses in both feet. They say that no workup thus far has been done with regards to the absent pulses. Given the active smoking history and absent pulses bilaterally and without epidural steroid injections, I would not find that the claimant has yet failed exhaustive conservative care and is not yet considered to be a reasonable candidate. Thus, I would deny this medical necessity of the requested surgical decompression at L3-L4 and L4-L5. Should further records or peer discussion become available I will be happy to taken this into consideration.”*

On February 28, 2013, , a pain management specialist, evaluated the patient for lower back and leg pain. It was noted that the patient had a history of Worker's Comp injury roughly five years ago for which he was originally treated conservatively and deferred recommended surgery. He reported having epidural steroid injection (ESI) done at that time with therapy. He recently had exacerbation and increase of his pain. The patient was referred for an ESI to assess his response to nonsurgical measures. The patient stated he felt that an injection will not fix his problem. He complained of knifelike sharp stabbing pain worse with standing, walking and lifting. He felt better when lying down or sitting and relaxing. Pain medications helped him. Ultram was not strong enough. He was utilizing Etodolac and Tramadol. Examination of the lumbosacral spine showed decreased range of motion (ROM) in all planes, positive sitting straight leg raise (SLR) bilaterally and spasm in the right lumbar region. reviewed the MRI findings and assessed herniated lumbar disc with radiculopathy, back pain with radiculopathy and lumbosacral radiculitis. He recommended a transforaminal lumbar ESI on the right at L3-L4.

On March 26, 2013, noted the patient continued to have pain. He assessed unresolved spinal stenosis secondary to disc herniation at L3-L4 and L4-L5. He reported that a pain management doctor had felt that injections were not indicated and would not work. He recommended resubmitting the request for surgery and emphasized to the patient the importance of becoming a nonsmoker.

Per reconsideration review dated May 16, 2013, the request for surgical decompression at L3-L4 and L4-L5 using the microdiscectomy, right-sided approach was denied by M.D., with the following rationale: *“ODG criteria for lumbar decompression include clinical radiculopathy, corresponding imaging findings demonstrating neurocompressive lesions, failure of conservative care, and a support provider referral. May 15, 2013, 2:24 p.m. phone conversation with ., PA, a designated representative speaking on behalf. It was discussed that the patient has absent posterior tibial and dorsalis pedis pulses. The popliteal and femoral pulses were not examined. The patient continues to smoke. Review of the notes have minimal physical examinations, if any, except for the initial November 13, 2012, consultation with no motor, sensory, or reflex changes. The March 26, 2013, letter of reconsideration indicates that the patient was sent to pain management however, there were no recommendations for injections. It was reviewed with that there is a February 28, 2013, pain management note with recommendations for transforaminal lumbar epidural steroid injection on the right at L3-L4. She had no knowledge of this and was unclear whether injections had been performed. Given the lack of adequate vascular workup, no objective findings of radiculopathy on physical examination, the last examination being performed six months ago, recommendations from pain management for epidurals, recommendation is to non-certify.”*

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

Surgical decompression L3-4 and L4-5 using microdiscectomy right-sided approach would not be considered medically necessary or appropriate in this case based upon the Official Disability Guidelines.

Official Disability Guidelines support discectomy to help treat radiculopathy when patients fail appropriate conservative care of at least two months' duration. Official Disability Guidelines require symptoms and findings which confirm the presence of radiculopathy with concordance between radicular findings on physical examination and radiographic evaluation.

The records provided for review in this case do not document any type of neurologic examination of the claimant's lower extremities. The records provided document back and leg pain and absent pedal pulses. The MRI performed in this case demonstrates mild to moderate bilateral foraminal stenosis at the L4-5 level and moderate right and mild left foraminal stenosis at the L3-4 level. There is documentation that this claimant has been treated appropriately conservatively.

Absent findings of radiculopathy by physical examination that correlate to imaging studies, discectomy cannot be certified in this case.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES