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Notice of Independent Review Decision

June 7, 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:

Board Certified Orthopedic Surgeon

I certify that I hold appropriate credentials to conduct this review; summary of qualifications: I received my medical degree from The University of Pittsburgh School of Medicine; I went on to complete my internship and residency at Pennsylvania State University and completed a Total Joint Replacement Fellowship at Emory University. I have 16 years of experience producing Peer Reviews supported by evidence-based medicine. I hold an active and unrestricted Texas license, and have experience with worker's compensation claims in Texas.

REVIEW OUTCOME:

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

Overturned (Disagree)

Medical documentation supports 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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who on xx/xx/xx, while lifting cases, she experienced a popping sound in her back.

PRE-INJURY RECORDS

2010: On May 5, 2010, evaluated the patient. She allowed the patient to return to work without restrictions as of May 6, 2010. Per work release form dated May 16, 2010, the patient was allowed to return to work two days from May 16, 2010, without restrictions.

POST-INJURY RECORDS

2011: Per an Associate Statement dated March 11, 2011, the patient described having back pain.

On March 23, 2011, evaluated the patient for intense and sharp back pain radiating into the hips and left leg and also sleep disturbance. Associated symptoms included numbness and tingling sensation in the left lower leg. History was significant for hypertension, anemia and stroke. The patient reported she did not seek medical care and was taking over-the-counter (OTC) pain medication without significant relief in her symptoms. Examination of the lumbar spine revealed moderate tenderness and spasm of the lumbar spine and paraspinal muscles, tenderness of the erector spinae muscles and sacroiliac (SI) region bilaterally. Range of motion (ROM) was limited in flexion and extension. Torso twisting and side bending elicited low back pain. Bechterew's test and Braggard's test elicited low back pain and left leg pain. There were multiple trigger points in

the left quadratus lumborum, gluteus medius, piriformis and hamstring muscles. diagnosed lumbar radiculitis, limited lumbar ROM and myospasm and recommended participating in active rehabilitation program three times a week for two weeks.

On April 7, 2011, the patient underwent x-rays of the lumbar spine that showed minimal splinting of the lumbar spine on the anteroposterior view, typical for muscle spasm.

On April 18, 2011, noted the patient underwent a few sessions of therapy and it helped reduce her pain. recommended continuing active rehabilitation program.

On April 19, 2011, evaluated the patient for low back pain and numbness down the left leg. Examination of the lumbar spine showed slight tenderness, but full ROM of the back. diagnosed lumbalgia and lumbar spasm, prescribed Norflex and Daypro and recommended continuing physical therapy (PT). The patient requested steroids, which she had taken in the past for pain, but recommended treating the patient with more conventional methods before starting a steroid therapy.

On May 18, 2011, recommended continuing active rehabilitation program and obtaining magnetic resonance imaging (MRI) of the lumbar spine to rule out herniated nucleus pulposus (HNP).

On May 20, 2011, MRI of the lumbar spine showed: (1) Moderate low signal changes in the L4-L5 and L5-S1 discs. (2) Cuts at L3-L4 demonstrating a 2-mm posterior protrusion with 5% effacement of the thecal sac. The neural foramina at that level showed only 15% encroachment on the left and right. Cuts at L4-L5 demonstrated a 3-mm posterior disc herniation. There was 20% effacement of the thecal sac with estimated 60% spinal stenosis. There was significant hypertrophic change along the facets at that level. The neural foramina showed estimated 25% encroachment on the right and 30% on the left. The exiting nerve root on the left was abutted with no obvious edema, but clinical correlation with regard to that level with the hernia and stenosis was requested. (3) Cuts at L5-S1 demonstrated a 2-mm posterior protrusion. The internal nerve roots were abutted, but did not show displacement or effacement. There was moderate hypertrophic change along the facets at that level.

On May 31, 2011, reviewed the MRI findings and diagnosed multiple disc protrusions in the lumbar area, possible lumbar radiculopathy and muscle spasms. He prescribed Orudis, Flexeril and Lortab and recommended continuing PT and obtaining an orthopedic evaluation and an electromyography/nerve conduction velocity (EMG/NCV) study.

Per utilization reviews dated June 10, 2011, the requests for EMG/NCV studies of the bilateral lower extremities and PT for the lumbar spine three times a week for two weeks were denied.

From June 15, 2011 through September 27, 2011, treated the patient for lumbar disc protrusion, lumbar spine canal stenosis, possible lumbar radiculopathy, myospasms and myofascial strain. noted the patient had attended 12 sessions of PT. She recommended EMG/NCV, an orthopedic evaluation, continuing active rehabilitation and obtaining a functional capacity evaluation (FCE) to determine current physical demand level (PDL). continued medications and ordered EMG/NCV study of the bilateral lower extremities.

On October 10, 2011, the patient was evaluated. The efforts demonstrated by the patient indicated a current work capacity characterized by the sedentary PDL for work above the waist and sedentary PDL for work below the waist, so the overall whole body PDL was sedentary. recommended EMG/NCV study and an orthopedic consultation.

From October 19, 2011 through December 6, 2011, treated the patient with medications. Flexeril was changed to Robaxin.

Per utilization review dated November 8, 2011, the request for EMG/NCV of the bilateral lower extremities was denied.

2012: In January, recommended an EMG/NCV study and possible injections, continued medications and referred the patient for an orthopedic evaluation.

On January 26, 2012, the patient underwent electrodiagnostic evaluation that showed no definitive diagnostic of radiculopathy. The pattern of chronic denervation with re-innervation with unattainable H-reflexes was suggestive of a possible history of chronic and bilateral L5-S1 radiculopathy, left more severe than right. The patient was recommended a pain medicine consultation regarding epidural steroid injections (ESI) and undergoing an MRI of the lumbar spine.

On February 7, 2012, noted that the patient was complaining of a different pain than her usual pains from her motor vehicle accident (MVA) that she had on January 30, 2012. The pain that the patient attributed to that was body aches in her back, neck, and arm. It felt more like stiffness than anything else. recommended continuing medications and starting PT for her new injuries.

On February 16, 2012, evaluated the patient for low back pain and left leg pain, as well as neck pain and left shoulder pain. He diagnosed back pain with radiation, displacement of lumbar intervertebral disc without myelopathy and lumbar intervertebral disc without myelopathy. He fitted a back brace and recommended proceeding with a left transforaminal ESI at L4-L5.

On February 22, 2012, noted that the patient had undergone an EMG/NCV of lower extremities on January 21, 2011, which suggested chronic and bilateral L5-S1 radiculopathy.

On March 2, 2012, performed a transforaminal ESI at left L4 and L5.

On March 20, 2012, noted 10% improvement after the lumbar ESI. He scheduled the patient for two more ESIs at the left L4-L5.

From March 21, 2012, through May 4, 2012, treated the patient with Lortab, Elavil, Robaxin and Orudis.

Per utilization reviews dated March 28, 2012, April 27, 2012, and May 8, 2012, the requests for NCV test, transcutaneous electrical nerve stimulation (TENS) unit and transforaminal ESI at left L4-L5 x2 respectively were denied.

On May 8, 2012, x-rays of the thoracic spine showed mild splinting of the lower thoracic spine typical for muscle spasm. X-rays of the left shoulder showed a superior offset of the distal clavicle with relation to the acromion consistent with partial dislocation. X-rays of the cervical spine showed mild reversed lordosis of the spine typical for muscle spasm.

On May 14, 2012, an orthopedic surgeon, evaluated the patient for lumbar pain radiating into both legs and weakness in the left lower extremity. reviewed the previous diagnostic studies and diagnosed HNP, L4-L5 with left greater than right L5 radiculopathy. He recommended requesting the actual MRI films and then seeing the patient back to recommend lumbar laminotomy and microdiscectomy.

On May 24, 2012, evaluated the patient for a new complaint of left knee pain. The patient reported that she was getting in the car and her left knee just gave out on her. Her left leg went numb and had no strength in it. She fell on her knee. She stated that it was painful, tender and there was pain with ROM. recommended obtaining an MRI of the left knee.

On June 16, 2012, performed a designated doctor examination (DDE) and assessed clinical maximum medical improvement (MMI) as of July 29, 2011, with 0% whole person impairment (WPI) rating. opined that the patient had a prior back injury and received treatment by her family physician. She was advised to return to work in 2010. There was also a question about the causality of that claim since the patient was dismissed the following day after she claimed to have the injury. The employer had disputed that injury. impression was that some of the findings on the MRI scan pre-existent to the injury were not significant to require extensive treatment. The EMG study was non-diagnostic and the problem should have resolved within six to eight weeks period.

On June 21, 2012, continued medications.

On July 24, 2012, disagreed with the designated doctor opinion.

On July 27, 2012, assessed clinical MMI as of July 24, 2012, with 10% WPI rating.

From August 2, 2012, through December 6, 2012, treated the patient. prescribed a walker with a hand brace with seat attachment. referred the patient for evaluation and recommendations and recommended undergoing an FCE to determine current PDL.

In October, referred the patient for evaluation and recommendations.

On December 19, 2012, evaluated the patient for constant pain and discomfort with side-to-side movements, soreness and stiffness in the low back. The patient had right lower extremity symptoms that included numbness, tingling and weakness. Previously the surgical intervention was discussed. The patient was considering surgical intervention, but wanted to try non-operative treatment at that time. discussed with her options that included lumbar laminectomy and foraminotomy and discectomy at L4-L5 and recommended proceeding with additional lumbar ESIs.

On December 26, 2012, recommended continuing conservative management, pain medicine consultation, obtaining MRI of the lumbar spine and an electrodiagnostic evaluation in three to four months if there was no progression in signs and symptoms. She commented that the patient was asymptomatic prior to the injury.

On December 27, 2012, noted the patient was utilizing Lortab, Anaprox, Robaxin and Elavil. She recommended follow-up for medication management, obtaining MRI of the lumbar spine with contrast and follow-up with an orthopedic surgeon once MRI was obtained.

2013: Per the utilization review dated January 7, 2013, the request for one follow-up visit between January 2, 2013, and March 3, 2013, MRI of the lumbar spine with contrast between January 2, 2013 and March 3, 2013, and lumbar spine x-rays between January 2, 2013 and March 3, 2013, was denied.

On January 10, 2013, recommended obtaining MRI of the lumbar spine and undergoing an additional lumbar ESI.

Per utilization review dated January 15, 2013, the request for ESI at L4-L5 level was denied.

On January 31, 2013, suggested waiting for the IRO decision regarding the lumbar ESI in conjunction with post-injection PT. Depending upon the results of the IRO, the patient might be a candidate for additional diagnostic studies to proceed with lumbar laminectomy with foraminotomy and discectomy at L4-L5 on the left. The patient's medication should be continued by the treating doctor.

Per reconsideration review dated February 6, 2013, the appeal for lumbar ESI at L4-L5 level between was denied.

On February 19, 2013, recommended continuing medications, obtaining MRI of the lumbar spine and follow-up with an orthopedic surgeon after obtaining the MRI.

Per the February 27, 2013, report, IRO upheld the previous adverse determination for ESI at L4-L5.

On February 28, 2013, MRI of the lumbar spine showed: (1) Moderate low signal change in the L4-L5 and L5-S1 disc. (2) Cuts at L3-L4 did not show any posterior protrusion. The neural foramina were adequately maintained. (3) Cuts at L4-L5 showed a 2-3-mm posterior herniation with 10% effacement of the thecal sac. The neural foramina did not show any severe encroachment and there was no suggestion of entrapment.

On March 15, 2013, prescribed Lortab, Anaprox, Robaxin and Elavil and recommended follow-up with the orthopedic surgeon.

On March 20, 2013, reviewed the MRI findings and recommended follow-up with follow-up with an orthopedic surgeon and undergoing a Behavioral Health Assessment.

On April 4, 2013, noted the patient continued to remain symptomatic and she had been through an abundant course of non-operative treatment including oral non-steroidal anti-inflammatory drugs (NSAIDs), activity modification, PT, and lumbar ESI, which gave her temporary relief. reviewed the MRI findings of the lumbar spine that revealed disc derangement and stenosis, which was consistent with physical examination and radiculopathy. recommended lumbar laminectomy/foraminotomy/microdiscectomy at left L4-L5.

On April 9, 2013, noted tenderness and spasms in the lower back muscles, pain with ROM, guarded gait and numbness down her left lower leg. He recommended continuing medications and follow-up with orthopedic surgeon.

On April 17, 2013, recommended follow-up as needed for medication management and orthopedic surgeon.

On April 29, 2013, evaluated the patient to assist further in assessing difficulty with pain and overall adjustment issues related to the patient's injury and to determine whether mental health factors were inhibiting treatment benefit and ability to return to work and to determine if the patient would be suitable for and would benefit from psychological services. The patient scored 43/63 on Beck Depression Inventory (BDI) and 34/63 on Beck Anxiety Inventory (BAI). The patient was diagnosed with pain disorder associated with both psychological factors and a general medical condition, major depressive disorder, moderate, lumbar disc protrusion, canal stenosis of the lumbar spine, lumbar radiculopathy, chronic back pain, and myospasm, anemia, hypertension, and stroke and physical, psychological, occupational, social, and financial problems. The patient

was experiencing both physical and emotional reaction to the xx-xx-xx, injury. She showed symptoms of depression and anxiety. Her coping and stress management skills were ineffective. She was recommended individual psychological therapy.

Per utilization review dated April 30, 2013, the request for laminectomy/foraminotomy/microdiscectomy, single vertebral segment lumbar L4-L5 left between April 25, 2013 and June 24, 2013, was denied based on the following rationale: *"In this particular case, it appears proceeding with the requested surgery is not warranted. The provider has recommended a left L4-L5 laminectomy/foraminotomy/microdiscectomy. Physical examination revealed significant weakness in extension of the great toe and dorsiflexion of the ankle, decreased sensation noted in the left L5 dermatome, and left straight leg raise testing elicited pain down to the foot. The patient has attempted activity modifications, NSAIDs, physical therapy and lumbar epidural steroid injections without lasting results. However, the recent MRI study revealed a posterior disc herniation at L4-L5. The MRI report also specifically indicated that neural foraminal encroachment was not severe, and there was no evidence of nerve root compression. As a L4-L5 laminectomy/foraminotomy/microdiscectomy is being requested, specifically on the left side, guidelines state that at least either nerve root compression, a lateral disc rupture or lateral recess stenosis must be clearly defined to correlate with positive examination findings prior to undergoing surgery. For this reason only, the request is not medically indicated at this time. Therefore, the request for one left L4-L5 laminectomy/foraminotomy/microdiscectomy is recommended non-certified."*

On May 9, 2013, evaluated the patient for chronic back pain. noted that an additional course of steroid injection was declined by the insurance provider. The orthopedic surgeon was trying to get surgery approved. The patient continued with back pain that radiated down her leg, weakness and numbness in her lower legs more marked on the left. She had edema in her lower legs. Examination of the back showed decreased ROM, pain with flexion and extension, tenderness of the back muscles, muscle spasm in lower back, and left buttock region. Neurological examination showed guarded gait. The patient was walking with a stiff back. She had numbness down her left lower leg. diagnosed HNP at L4-L5 interspace, lumbar radiculopathy, lumbar spasm and chronic back pain, prescribed Lortab, Anaprox, Robaxin and Elavil and recommended participating in a pain management program and follow-up with orthopedic surgeon.

Per reconsideration review dated May 16, 2013, the appeal for laminectomy/foraminotomy/microdiscectomy single vertebral segment lumbar L4-L5 left between April 25, 2013, and June 24, 2013, was denied based on the following rationale: *"It appears that based on the interpretation of the guidelines, the original non-certification was appropriate. While the patient has failed all the necessary conservative treatments, the findings on the MRI do not meet the criteria for surgery. There was no lateral disc rupture, and while 60% spinal stenosis was present at this level, lateral recess stenosis was not specifically*

noted. Also, while the neural foramina showed 30% encroachment on the left with abutment of the exiting nerve root, no edema or compression was noted. The imaging findings are not severe enough for the guidelines to indicate surgery. Therefore, this request for one left L4-L5 laminectomy/foraminotomy/ microdiscectomy is recommended non-certified."

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

All of the information provided was carefully reviewed in consideration of determining the medical necessity of lumbar laminectomy and foraminotomy.

The records in this particular case note that the claimant has a constellation of clinical complaints and physical examination findings that would be consistent with an L4-5 radiculopathy. In particular, she reportedly has demonstrable weakness in her extensor hallucis longus and dorsiflexors that are consistent with the above-stated diagnosis. Furthermore, the records note that the claimant has failed a reasonable course of conservative care including activity modification, medical management, and physical therapy. In addition, an epidural steroid injection offered her temporary relief which would be considered diagnostic.

At issue in this particular case is whether or not the claimant has sufficient neural compression at L4-5 that would benefit from decompression at that level.

Imaging studies have documented some degree of neural foraminal stenosis at L4-5. The exact degree appears to be somewhat debatable based on the interpretation of the radiologist, the independent reviewers. Acknowledged in this particular case is that there is some degree of neural foraminal stenosis at L4-5.

In general, the most significant part of determination as to whether or not patients may benefit from surgery is to whether or not the claimant's clinical picture is supported by physical examination findings and imaging. Clearly the claimant has a constellation of complaints consistent with radiculopathy, and although the imaging studies do not describe severe stenosis, there is nevertheless stenosis at the left side that would be consistent with the demonstrable findings on exam. The fact that the claimant got temporary relief with an epidural steroid injection would further support contention that the claimant does in fact suffer from radiculopathy.

As such, based on careful consideration of all the information provided and in consideration of the evidence-based Official Disability Guidelines, the request would be considered reasonable and medically necessary in this setting.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines, Treatment in Worker's Comp 18th edition, 2013
Updates : Low Back

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).