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Notice of Independent Review Decision

DATE: February 28, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar Spine Laminectomy and Foraminotomy at L5-S1 #63047, #63048, #69990

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is certified by the American Board of Orthopaedic Surgeons with over 40 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:
07/27/10: L-Spine 2 or 3 Views report interpreted by MD with
07/27/10: Office Visit by MD with
08/03/10: Office Visit by PA-C/ MD with
08/24/10: Consultation Notes by MD
09/14/10: MRI Lumbar Spine Report interpreted by MD with Imaging
09/15/10: Office Visit by DC
09/21/10, 01/03/11, 01/31/11, 03/22/11: Followup Visit by MD
09/30/10: Office Visit by MD with Center for Specialties, PA
10/01/10: EMG and NCV Findings by MD with
10/27/10, 01/19/11: Procedure Note by MD
03/24/11: Designated Doctor Evaluation by MD with
08/01/11: Designated Doctor Evaluation by MD
12/15/11: Followup Visit by MD

01/12/12: Office Visit (No facility or provider name given)
02/06/12: Followup Visit by MD
05/09/12: Orthopedic Consult by MD with Orthopedics
06/15/12: Operative Report by MD
06/15/12, 08/27/12, 12/14/12: Orthopedic Report by MD
10/22/12: MRI Lumbar Spine W/O Contrast Report interpreted by MD with Imaging
12/13/12: Patient Information Sheet from Health
01/08/13: Diagnostic Imaging/Testing Referral Slip by MD
01/15/13: Surgery Reservation Sheet from Orthopedics
01/18/13: UR performed by DO
01/18/13: Letter from
01/28/13: Orthopedic Consult by PA/ MD
02/04/13: Reconsideration Request by with Orthopedics
02/05/13: Letter from
02/06/13: UR performed by MD
02/07/13: Letter from
02/15/13: Manual Muscle Strength Exam by MD

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who injured her low back at work when she slipped on the floor on xx/xx/xx.

Xx/xx/xx: L-Spine 2 or 3 Views report interpreted by, MD. IMPRESSION: Degenerative changes, as discussed. No fracture or malalignment identified.

09/14/10: MRI Lumbar Spine report interpreted by MD. IMPRESSION: L5-S1: There is narrowing of the disc with 3-mm diffuse posterocentral disc bulge. There is bilateral facet hypertrophic changes and bilateral foraminal stenosis, left more than right. L4-L5: There is left paracentral 3-mm broad-based disc bulge. There are facet hypertrophic changes and mild left foraminal stenosis. There is mild central spinal stenosis. The AP diameter measures 9 mm. L3-L4: There is dehydration desiccation of the disc with 4-mm diffuse posterocentral disc bulge. There is mild facet hypertrophic changes and mild central spinal stenosis. AP diameter measures 9 mm. L2-L3: There is 2 mm posterocentral disc bulge. L1-L2: there is 2 mm posterocentral disc bulge. There is indentation of the ventral thecal sac. Age is indeterminate.

10/01/10: EMG and NCV Findings by MD. Electrodiagnostic evidence of right L5 radiculopathy. Peripheral polyneuropathy.

10/27/10: Procedure Report by MD. ASSESSMENT: Lumbar Radiculopathy. PROCEDURES: Right L4-L5 and L5-S1 transforaminal ESI.

01/19/11: Procedure Report by MD. ASSESSMENT: Lumbar Radiculopathy. PROCEDURES: Right L4-L5, L5-S1 transforaminal ESI.

01/31/11: The claimant was evaluated by, MD who noted that the transforaminal ESI gave her 50% relief for two days, and then the pain slowly returned.

08/01/11: Designated Doctor Evaluation by MD. IMPRESSION: Persistent, mild, right S1 radiculopathy now with some radicular findings on examination, which I did not note on my previous examination on 24 March 2011. The patient also has an abnormal lumbar MRI scan and positive electrodiagnostic studies that correlate with her examination and MRI scan findings.

05/09/12: The claimant was evaluated by, PA/, MD. It was noted that she was started on a physical therapy program by Dr.. She stated that she underwent lumbar epidural steroid injections by Dr., which gave her good results. She stated that SI joint injections gave her temporarily relief. At this visit, she complained of low back pain rated as 9/10 with constant pain in the back area which radiated down both lower extremities with numbness and tingling. On exam, she had right lower extremity pain. She had difficulty getting out of a chair and onto the exam table. She had tenderness on her right L4 and L5 region. She had a positive Kemp sign. She had decreased range of motion with flexion and extension. She had mild pain in her bilateral sacroiliac joint areas, right greater than left. She had limitations with extension of the lumbar spine. SLR elicited back pain only. Her motor strength was weakened in the lower extremities, mostly due to back pain. She had mild paresthesias in a left L5 distribution as compared to right. DTRs were 2+ at the knees and ankles bilaterally. Her gait was slow. She was able to heel-toe walk, walk on toes, and walk on heels with moderate difficulty. Review of her MRI revealed disc collapse at L5-S1 with disc protrusions causing stenosis bilaterally, left greater than right. There was also facet hypertrophy noted at L5-S1 bilaterally, left greater than right. X-rays revealed decreased disc height at L5-S1. IMPRESSION: Disc derangement, L5-S1 with neurogenic claudication and stenosis. Facet pain at right L4, right L5, and right S1. PLAN: At this point, the patient's symptoms seem to be between neurogenic claudication and mechanical back pain. She is complaining primarily of axial mechanical back pain at this office visit. At this time, we are interested in evaluating a diagnostic medial branch block at right L4, right L5, and right S1 levels. Depending on how the patient does with a diagnostic branch block, she would be a candidate for a radiofrequency ablation. We also discussed the possibility of surgical intervention to treat her neurological claudication. Procedure, risks, and benefits were discussed with the patient and informative handouts were given. The patient will continue her medication as previously prescribed by her pain management doctor.

06/15/12: Operative Report by, MD. POSTOPERATIVE DIAGNOSIS: Lumbar facet strain/syndrome. PROCEDURES: Lumbar medial branch block L4 facet nerve right. Lumbar medial branch block L5 facet nerve right. Lumbar medial branch block S1 facet nerve right. Fluoroscopic localization needle, lumbar. The patient noted 20-25 % relief of the back pain prior to discharge.

06/15/12: Dr. noted that the claimant had a small amount of improvement after the medial branch block, but she rated it somewhere around 20-25%

improvement. She stated that the medial branch block and her sacroiliac injection had no significant effect on her back pain. It was noted that the first lumbar epidural injection gave her positive effects. Dr. noted that her MRI showed a protrusion at L5-S1 with bilateral foraminal stenosis and that her EMG showed evidence of a right L5 nerve root irritation. He also stated that she had paresthesias along the bilateral L5 distribution. She had back, hip, and leg pain, positional in nature and consistent with neurogenic claudication. Dr. recommended a lumbar laminectomy and foraminotomy at L5-S1 bilaterally to address her for neurogenic claudication.

08/27/12: The claimant was evaluated by PA-C/, MD. It was noted that the request for lumbar surgery was denied and that the peer reviewer stated that the diagnostic imaging studies submitted for review were approximately two years and that ODG criteria were not met. It was noted that the claimant presented on 08/27/12 with low back pain rated 8/10 with lower extremity numbness, tingling, and weakness. On exam, there was tenderness on the mid-lower lumbar region with decreased range of motion with flexion/extension. SLR was positive for leg pain and back pain bilaterally. She continued to have paresthesias along her left L5 distribution. Her reflexes were 1+ in her patellae and Achilles. Her gait remained slow. She was unable to heel-tow walk, walk on toes, or walk on heels due to pain in her low back and lower extremities. IMPRESSION: Disc derangement of the lumbar spine, L5-S1, with neurogenic claudication and stenosis. PLAN: With regard to the patient's lumbar spine, she continues to remain symptomatic. She has exhausted physical therapy and oral anti-inflammatories. She has increased neurological symptoms in both lower extremities. We will proceed with an MRI with and without contrast of her lumbar spine. We will recommend Dr. obtain this diagnostic study. We will see her back following this study to review her results. As per the patient's peer reviewer and the first denial regarding her recommended surgical intervention, they would like to have her obtain updated studies to evaluate her prior to authorizing her surgery.

10/22/12: MRI Lumbar Spine W/O Contrast report interpreted by MD. IMPRESSION: L1-L2: Desiccation and loss of normal water content with narrowing of the L1-L2 disc space. 1-mm ventral bulging disc. Associated spinal stenosis. AP dimension of the bony spinal canal narrowed to 9 mm. No lateralized defect nor focal disc herniation. L2-L3: No ventral defect. No focal disc herniation nor bony spinal stenosis. Normal hydration of the L2-L3 disc. L3-L4: Desiccation and loss of normal water content. 1-mm ventral bulging disc. Associated spinal stenosis. AP dimension of the bony spinal canal narrowed to 8 mm. No lateralized defect nor focal disc herniation. L4-L5: Desiccation and loss of normal water content. Degenerative changes and hypertrophy of the right and left L4-L5 facet joints. No ventral defects. No focal disc herniation nor bony spinal stenosis. L5-S1: Desiccation and loss of normal water content. Narrowing of the L5-S1 disc space. No ventral defect. No focal disc herniation nor bony spinal stenosis. Mild degenerative changes within the right and left L5-S1 facet

joints. Overall, MRI scan of 10/22/12 shows no significant interval change from previous MRI scan of 09/14/10.

12/14/12: The claimant was evaluated by, PA-C/, MD for low back pain, which she rated as 7/10 with constant pain, discomfort with side-to-side movements, soreness, and stiffness. She continued to experience lower extremity symptoms that included numbness, tingling, and weakness. On physical exam, she had severe tenderness on the mid-lower lumbar region with decreased range of motion with flexion and extension. SLR positive for leg pain and back pain. Paresthesias along left L5 distribution. DTRs 1+ patellae and Achilles. Slow gait. Difficulty heel-toe walking, walking on toes, and walking on heels due to pain in her low back and lower extremities. Review of her MRI demonstrated disc derangement desiccation at L5-S1 with stenosis. It was noted that it was compared to MRI dated 09/14/10, which revealed bilateral foraminal stenosis, left more than right, and mild central stenosis. PLAN: The patient continues to remain symptomatic. She has exhausted physical therapy and oral anti-inflammatories as well as lumbar ESIs. We will proceed with the recommended lumbar laminectomy and foraminotomy at L5-S1.

01/18/13: UR performed by, DO. RATIONALE: Based on the clinical documentation provided for review, there is insufficient documentation to support the request per guideline recommendations. No imaging studies of the lumbar spine were submitted for review demonstrating pathology to include foraminal stenosis or spinal canal stenosis at L5-S1 that would reasonably require laminectomy or foraminotomy. The patient's physical examination findings did not clearly show evidence of neurological deficits supporting a diagnosis of lumbar radiculopathy. It is also unclear what conservative treatment the patient has completed to date. It appears that the patient is still undergoing physical therapy and it is unclear whether physical therapy was discontinued due to lack of response. It is also unclear if the patient attended any epidural steroid injections as recommended by guidelines. As the clinical documentation provided for review does not meet guideline recommendations for the quest, medical necessity is not established.

01/28/13: Orthopedic Report by PA/, MD notes that MRI dated 10/22/12 demonstrated "stenosis with narrowing, consistent with her physical examination." It was noted that her "physical examination revealed severe tenderness upon palpation with limitation of range of motion with flexion and extension. Straight leg raises were positive for leg pain and back pain. She had paresthesias along her left L5 distribution. Her reflexes remained 1+ in her patellae and Achilles." It was noted that she had been through an abundance course of nonoperative treatments including physical therapy and oral anti-inflammatories as well as medial branch block as a diagnostic injection to evaluate a component of her axial mechanical back pain. It was noted that the block did not give her any relief. It was noted that physical exam and lower extremity EMGs were consistent with nerve root irritation.

02/06/13: Ur performed by MD. RATIONALE: The clinical documentation submitted for review evidences the patient has utilized supervised therapeutic interventions, injections, and a medication regimen for her lumbar spine complaints. Electrodiagnostic studies evidenced right L5 radiculopathy. However, the imaging study of the patient's lumbar spine dated 10/24/12, signed by Dr. revealed mild degenerative changes within the right and left L5-S1 facet joints; no documentation of central canal stenosis, nerve root impingement, or other pathology was evidenced to support the requested surgical interventions at this point in the patient's treatment. Given the above, the request for the lumbar spine laminectomy and foraminotomy at L5-S1 is not medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse decisions are upheld. The last MRI report does not describe an impingement. The claimant's last physical exam does not show S1 nerve involvement. Her complaints are not typical of an S1 nerve root impingement. She does not meet the ODG criteria for surgery. Therefore, the request for Lumbar Spine Laminectomy and Foraminotomy at L5-S1 #63047, #63048, #69990 is not medically necessary and is not certified.

ODG:

Laminectomy/ laminotomy	Recommended for lumbar spinal stenosis. For patients with lumbar spinal stenosis, surgery (standard posterior decompressive laminectomy alone, without discectomy) offered a significant advantage over nonsurgical treatment in terms of pain relief and functional improvement that was maintained at 2 years of follow-up, according to a new SPORT study. Discectomy should be reserved for those conditions of disc herniation causing radiculopathy. Laminectomy may be used for spinal stenosis secondary to degenerative processes exhibiting ligamental hypertrophy, facet hypertrophy, and disc protrusion, in addition to anatomical derangements of the spinal column such as tumor, trauma, etc. (Weinstein, 2008) (Katz, 2008) This study showed that surgery for spinal stenosis and for disc herniation were not as successful as total hip replacement but were comparable to total knee replacement in their success. Pain was reduced to within 60% of normal levels, function improved to 65% normal, and quality of life was improved by about 50%. The study compared the gains in quality of life achieved by total hip replacement, total knee replacement, surgery for spinal stenosis, disc excision for lumbar disc herniation, and arthrodesis for chronic low back pain. (Hansson, 2008) A comparison of surgical and nonoperative outcomes between degenerative spondylolisthesis and spinal stenosis patients from the SPORT trial found that fusion was most appropriate for spondylolisthesis, with or without listhesis, and decompressive laminectomy alone most appropriate for spinal stenosis. (Pearson, 2010) In patients with spinal stenosis, those treated surgically with standard posterior decompressive laminectomy showed significantly greater improvement in pain, function, satisfaction, and self-rated progress over 4 years compared to patients treated nonoperatively, and the results in both groups were stable between 2 and 4 years. (Weinstein, 2010) Comparative effectiveness evidence from SPORT shows good value for standard posterior laminectomy after an imaging-confirmed diagnosis of spinal stenosis [as recommended in ODG], compared with nonoperative care over 4 years. (Tosteson, 2011) Decompressive surgery (laminectomy) is more effective for lumbar spinal stenosis than land based exercise, but given the risks of surgery, a self-management program with exercise prior to consideration of surgery is also supported. (Jarrett, 2012) Laminectomy is a surgical procedure for treating spinal stenosis by relieving pressure on the spinal cord. The lamina of the vertebra is

	removed or trimmed to widen the spinal canal and create more space for the spinal nerves. See also Discectomy/laminectomy for surgical indications, with the exception of confirming the presence of radiculopathy. For average hospital LOS after criteria are met, see Hospital length of stay (LOS).

Discectomy/ laminectomy	**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)**