

**IRO REVIEWER REPORT TEMPLATE -WC**

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Notice of Independent Review Decision

**[Date notice sent to all parties]:**

**09/04/2013**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** L4-5  
decompression, code 63047.

**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:

X 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:**

09/27/2011, Progress Note  
09/27/2011, Radiology Review  
10/13/2011, MRI Report, Lumbar Spine  
01/04/2012, Operative Report  
01/31/2012, Initial Physical Therapy Evaluation  
02/29/2012, Progress Note, Physical Therapy

03/30/2012, Patient Evaluation Plan of Care  
04/20/2012, Functional Capacity Evaluation, Physical Therapy  
08/02/2012, Progress Note  
09/10/2012, Myelogram and Post-Myelogram CT  
09/13/2012, Progress Note  
10/04/2012, Functional Capacity Evaluation  
10/30/2012, Progress Note  
01/18/2013, Radiology Review  
01/18/2013, Progress Note  
02/19/2013, Progress Note  
03/19/2013, MRI Report, Lumbar Spine  
05/01/2013, Progress Note  
05/09/2013, Psychological Evaluation  
06/25/2013, Utilization Review Determination  
07/25/2013, Utilization Review Determination

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant is a male. On xx/xx/xx, he was seen for initial consultation. At that time he described low back pain and some leg pain. He stated he fell back, hit his head, and he had pain ever since that time. On exam he had 5/5 strength testing and sensation was grossly intact. He had negative straight leg raise. He had some tenderness over the region of L2-3, L3-4, and L4-5, and had well-healed midline surgical incision. Impression was low back pain and leg pain with a previous fusion at L5-S1 appeared to be fused with retrolisthesis and instability noted at L2-3 and L3-4. X-ray review at that time of the lumbar spine revealed, at L2-3 and L3-4, there was significant retrolisthesis in those 2 segments and disc space narrowing was noted. He had a posterior fusion with wiring at L4-5. On 10/13/2011, MRI of the lumbar spine revealed (1) generous central canal stenosis at L4-5, secondary to extensive hypertrophic degenerative changes of the facet joints with associated generous lateral recess narrowing and abutment of the descending L5 nerve roots; (2) there was mild central canal stenosis at the L3-4 level with Modic type 1 degenerative end plate changes anteriorly and abutment of the exiting L3 nerve roots bilaterally; (3) there was also mild lateral recess narrowing at L1-2 abutting the descending L2 nerve roots bilaterally, and exam was read. On 01/04/2012, this claimant was taken to surgery for a preoperative diagnosis of spondylolisthesis at L3-4 with spinal stenosis at L4-5 with a previous fusion at L5-S1, solid in nature. Procedure performed was a corpectomy L3-4, corpectomy L4-5, anterior lumbar interbody fusion L3-4, L4-5, using allograft bone and bone marrow aspirate, bone marrow aspirate x3, implantation of a cage at L3-4 and L4-5, screw fixation at L3-4 and L4-5, and cellular grafting using platelet-rich plasma along with somatosensory evoked potentials. On 01/31/2012, 02/9/2013, and 03/30/2012, the claimant was seen.

On 08/02/2012, the claimant was seen back in clinic. He was still having complaints of pain to his left leg radiating down his leg in the L5 nerve root

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distribution. He also complained of some paresthesias in that same distribution. He noted his leg had been buckling as if he was going to fall. On exam, sensation was decreased in an L5 distribution and he had 4/5 strength testing. On 09/10/2012, a CT myelogram was performed. This exam revealed (1) prior surgery with posterior rod and screw fixation from L3 to L5 and bone graft posterior element fusion across L5-S1 with an L5-S1 laminectomy and L4 laminectomy; (2) there was anterior interbody fusions at L4-5 and L3-4 and the hardware appeared to be well-positioned; (3) there was moderate narrowing of the thecal sac at L4-5, in part due to prominent ligamentum flavum, contributing to moderate foraminal narrowing bilaterally, there was moderate narrowing of the thecal sac at L2-3 just above that fusion, due to disc disease and mild grade retrolisthesis. Exam was read. On 01/18/2013, the claimant returned and reported doing well from the surgery and was back at work, and then he slipped and fell on the ice, landing on his back. X-rays showed good position of the hardware and did not show any loosening of the hardware or failure of the fusion. On 03/19/2013, an MRI of the lumbar spine was obtained. This exam revealed the claimant to be status post prior surgery with a laminectomy at L3-4 going down to L5-S1 levels, and a posterior fusion at L3 to L5 levels. Additionally, there appeared to be interbody disc grafts at L3-4 and L4-5 levels, as well as partial acquired fusion at the L5-S1 level. There was evidence of edema in the posterior paraspinal muscles at L3-4 going down to S1-S2 levels, suggesting myositis. There was suggestion of moderate-severe spinal canal narrowing at the L4-5 level from degenerative changes, as well as mild spinal stenosis at the L2-3 level. There was also associated mild to moderate neural foraminal narrowing at the L2-3 level. He had mild effacement of the lateral recess at L4-5, as well as the left L4-5 level. Exam was read. On 05/01/2013, the claimant returned. No complete physical exam was documented for that date. On 05/09/2013, he was seen for psychological evaluation. It was noted then that surgery was not contradicted by a psychological evaluation and he had a good prognosis.

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

On 06/25/2013, utilization review was performed. It was noted at that time that the requested inpatient L4-5 decompression with length of stay x1 day was not medically necessary, but recent documentation evidencing the plan of treatment was not documented in the clinical notes provided for that review. Furthermore, the clinical notes report the patient had utilized a medication regimen since his most recent injury in 12/2012, but no documentation of supervised therapeutic intervention, injection therapy, or other active treatment modalities was indicated. Additionally, the provider failed to submit a thorough physical exam of the patient to support the requested surgical intervention. Guidelines utilized at that time demonstrated that symptoms, findings, and objective findings should be correlated and documented, as well as imaging studies to support surgical interventions to the lumbar spine. Without a thorough physical exam of the patient evidenced in the clinical notes submitted for documentation, and submitted documentation lacking exhaustion of

conservative care, the requested surgery was not considered medically necessary. A subsequent review was performed on 07/25/2013. It was noted then that the requested L4-5 decompression with 1 day length of stay was not considered medically necessary. It was lacking documentation of any therapeutic interventions, injection therapy, or other active treatment modalities, and lacking a thorough physical exam to support the requested surgical intervention. Additional records provided for this review indicate that the last clinical note was on 05/01/2013. At that time, the note indicates chief complaint was low back and left leg, but there was no physical exam documented for that date. As such, correlation with physical findings and imaging studies cannot be performed as recommended by guidelines. Additionally, it is noted that there is lack of significant current conservative care other than medication management for this claimant after his fall on the ice. Guidelines would support a reasonable amount of conservative care lacking severe progression of neurological deficits. As such, the previous determinations dated 06/25/2013 and 07/25/2013 are upheld.

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

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

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 ( $\geq$  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).