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Notice of Independent Review Decision

January 9, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Two day inpatient stay for L3-5 laminectomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board Certified in Neurological Surgery with over 16 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:
06/13/06: 2nd page of Lumbar CT report
11/07/06: Neurosurgical Follow-up report
02/02/07: UR regarding denied service of a Lumbar CT Scan
07/02/13: MRI of the Lumbar Spine
07/03/13: Progress Note
07/31/13: Note
08/11/13: Evaluation
10/10/13: Evaluation
10/21/13: UR performed
12/02/13: UR performed
12/02/13: EMG/NCV Lower Extremities
12/10/13: Progress Note
12/18/13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured while working on xx/xx/xx. She injured her lower back. Initial treatment included physical therapy and injection. In 2005 she underwent a fusion at L4-L5. In June of 2013 she began complaining again of lower back pain.

06/13/06: 2nd page of Lumbar CT report. Impression: Partial 1. There is graft within the disc space. There appears to be ossification within the central portion of the graft. There is posterior osteophyte spurring to the right of midline and also osteophytic spurring from the right facet complex, causing moderate to severe right foraminal narrowing. There has been a decompressive laminectomy. No spinal stenosis is noted. Mild facet hypertrophy is also noted. 2. Mild generalized disc bulge at L3-4. Mild facet hypertrophy is noted. No spinal stenosis or foraminal narrowing is noted. 3. Generalized disc bulge at L5-S1. Mild facet hypertrophy is noted. No spinal stenosis or foraminal narrowing is noted.

11/07/06: Neurosurgical Follow-up report. Follow up evaluation following minimally invasive lumbar fusion and instrumentation. She reported no radiating pain into her legs, no weakness and no numbness. She was able to tolerate all normal activities.

07/02/13: MRI of the Lumbar Spine. Impression: At L3-4 degenerative changes produce moderate central canal stenosis with mild bilateral neural foraminal stenosis. 2. Postoperative changes consistent with laminectomy, fusion, and a disk spacer at the L4-L5 level. Intermediate signal in the right lateral recess/proximal right foraminal region at this level may represent ossification, postoperative scarring, or less likely disc material. Further evaluation with post contrast MRI and/or CT myelogram may be helpful if clinically warranted. Although foraminal evaluation is somewhat limited secondary to postoperative changes there is suspected mild to moderate right and mild left neuroforaminal stenosis. No central canal stenosis. 3. L5-S1 degenerative changes produce minimal bilateral neural foraminal stenosis.

07/03/13: Progress Note. On physical examination she was unable to walk on toes or heels. Tenderness of both L-spine at the level of L4, L5 and S1 and the paraspinous muscles at those levels. Decreased active ROM. SLR negative bilaterally. Good muscle strength bilaterally. Plan: Refill Flexeril 10 mg, modified activity, referred to spine surgeon.

08/11/13: Evaluation for constant lower back pain made worse by sitting or standing too long. There is left leg pain but no numbness. On physical examination there was evidence of muscle guarding with extension. Straight leg raising test was negative at 70 degrees bilaterally. Foraminal compression test was positive bilaterally. Femoral nerve stretch test was negative bilaterally. Motor examination showed excellent strength. No atrophy. No evidence of dermatomal sensory deficits. Reflexes were 1+ with knee jerks bilaterally and 2+ with right ankle jerk, trace with left ankle jerk. X-rays obtained on 8/7/13 revealed on dynamic lateral flexion-extension views a stable spine. The height of the intervertebral disc spaces appeared to be narrowed at L3-4-5. There was status

post 360 L4-5 fusion with bilateral internal fixation with 2 rods and 4 pedicle screws. Vertebral bodies appeared of adequate density. Diagnosis: 1. Status post L4-5 360 degree fusion with internal fixation. 2. Spinal stenosis L3-4. Recommendations: If surgery is contemplated in the future, recommended decompressive L3-4 laminectomy to relieve her L3-4 stenosis.

10/10/13: Evaluation for back and greater left hip and leg pain. It was reported that the claimant received 2 weeks of therapy after being evaluated in June 2013, which helped transiently. No ESI had been performed. Current pain was a constant 7/10. She reported taking Ibuprofen, Norco and Flexeril. On physical exanimation restricted ROM of the lumbar spine. Tender to palpation. Sensory exam was normal to pin, touch and position. Reflexes were bilaterally symmetrical, no pathological reflexes with inconsistent decreased knee reflex on the left. Plan: possible decompressive laminectomy.

10/21/13: UR performed. Rational for Denial: A decompressive surgery would only be supported if there was evidence of a clinical radiculopathy including loss of strength in a specific myotomal pattern, loss of sensation in a specific dermatomal pattern, and loss of deep tendon reflexes. The claimant does not have these findings on physical examination. The MRI does not document any significant neural compression to support the necessity of a decompression. Since the requested procedure is not indicated this obviates the need for an inpatient length of stay. The records do not reflect any lower levels of care have been performed such as the use of anti-inflammatories, recent physical therapy, or a recent epidural steroid injection. The request for a lumbar laminectomy at L3-5 with a two day impatient length of stay is not certified.

12/02/13: UR performed. Rational for Denial: Based on the clinical data provided, no clear cut objective radiculopathy has been demonstrated. The patient's pain generators have not been clearly defined.

12/02/13: EMG/NCV Lower Extremities. Impression: This is an abnormal study. There is electrodiagnostic evidence to support subacute left L5 radiculopathy as supported by ongoing denervation in primarily left L5 myotome. There is no evidence to support peripheral polyneuropathy or bilateral focal tibial/peroneal neuropathy.

12/10/13: Progress Note. On physical examination, normal ROM. Tenderness to palpation. Motor Strength: 4/5 in the left foot extensors with mild atrophy and no fasciculations or tremor. Sensory exam was normal to pin, touch and position. Reflexes were bilaterally symmetrical, no pathological reflexes. Gait was normal.

12/18/13: UR performed. Rationale for Denial: The previous non-certification on December 2, 2013, was due to lack of clear objective evidence of radiculopathy documented. The claimant's pain generators have not been clearly defined.

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

The previous adverse determinations are upheld. This claimant has back and left leg pain without clear sciatica or claudication component. She did well after prior L4/5 instrumented fusion in 2005, after work injury in xx/xxxx, with return of low back pain in June 2013. On her physical exam, there are no sensory, reflex deficits, or straight leg raise findings but some left foot weakness is noted. Her last Lumbar MRI in June 2013 shows central L3/4 stenosis and lower extremity EMG/NCV shows left subacute L5 radiculopathy. Her EMG/NCV findings may be related to epidural scarring or arrachnoiditis. She had 2 weeks of PT but no trial of lumbar ESIs. There has been a trial of muscle relaxers and NSAIDs without relief. Given this patient's past history, a trial of lumbar ESIs followed by a PT regimen, is worthwhile to see if that provides adequate pain relief prior to considering surgery. A psychiatric pain evaluation to exclude depression is also recommended per ODG prior to considering the L3/L4 laminectomy. Therefore, the request for two day inpatient stay for L3-5 laminectomy at Medical Center is not medically necessary at this time.

PER ODG:

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).

ODG hospital length of stay (LOS) guidelines:

Discectomy (*icd 80.51 - Excision of intervertebral disc*)

Actual data -- median 1 day; mean 2.1 days (± 0.0); discharges 109,057; charges (mean) $26,219

Best practice target (no complications) -- *Outpatient*

Laminectomy (*icd 03.09 - Laminectomy/laminotomy for decompression of spinal nerve root*)

Actual data -- median 2 days; mean 3.5 days (±0.1); discharges 100,600; charges (mean) $34,978

Best practice target (no complications) -- *1 day*

Note: About 6% of discharges paid by workers' compensation.

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)**