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Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 20, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Outpatient Lumbar Laminectomy and Discectomy at bilateral L5-S1 (63030, 63710, 77003)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

REVIEW OUTCOME

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

XX Upheld (Agree)

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.73	63030		Prosp	1			Xx/xx/xx	xxxxx	Upheld
722.73	63710		Prosp	1			Xx/xx/xx	xxxxx	Upheld
722.73	77003		Prosp	1			Xx/xx/xx	xxxxx	Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx. The claimant was diagnosed with a lumbar sprain/strain, disc displacement L5-S1, and lumbar radiculitis.

A lumbar spine MRI was performed on October 16, 2012. This study documented:

1. There was multilevel facet arthropathy, including L2-L3, L3-L4, L4-L5 and L5-S1,

2. 2mm disc bulge and left paracentral annular tear at L5 S1. There were some multiple disc bulges including L2-L3 and L3-L4. There was moderate left and mild right neural foraminal narrowing at L2-L3. There was mild neural foraminal narrowing at L3-L4,
3. No evidence of central stenosis. No fractures could be seen.

The claimant attended physical therapy through February 14, 2013. The claimant was evaluated on February 27, 2013. Complaints of back and leg pain were reported. The pain was 60% in the back and 40% in the legs. The physical examination revealed restricted range of motion of the lumbar spine and normal gait was noted. There was pain with flexion and extension. Sacroiliac joint pain was noted with extension and right rotation. There was tenderness to palpation of the bilateral sacroiliac joints, and bilateral greater trochanter. Straight leg raise was positive bilaterally. Deep tendon reflexes were normal and symmetric. Sensation was intact bilaterally. There was mild weakness of the left extensor hallucis longus. Mobic and Ultracet were prescribed. A caudal epidural steroid injection was recommended.

The epidural steroid injection was performed on August 1, 2013. No complications were reported.

Upon re-evaluation on September 25, 2013, the claimant reported three days of relief after the injection. Continued back and bilateral leg pain was reported. Bilateral decompressive laminectomy and discectomy at L5-S1 was recommended. It was noted that fusion surgery may be required if the claimant failed to respond to the decompressive laminectomy.

Increased pain was reported on November 4, 2013. The claimant was taking gabapentin and Cymbalta for pain relief. The physical examination continued to show decreased range of motion and positive straight leg raise. Sensation was intact in both lower extremities. There was full strength in both legs, except for weakness which was now located in the right gastrocnemius. Decompression surgery was again recommended based on failure of previous conservative treatment.

Follow-up visits continued through May 14, 2014, and decompression at L5-S1 continued to be recommended.

A lumbar spine MRI was performed on June 6, 2014. This study documented:

1. L5-S1 degenerative disc disease. Midline disc protrusion, without mass effect,
2. Minimal disc bulging at the remaining levels, without significant stenosis,
3. Minimal L4-L5 and L5-S1 facet joint degeneration.

Follow-up visits continued. On September 17, 2014, the claimant reported that her leg pain had become extremely severe. It was noted that surgery had been denied twice. The physical examination revealed a normal gait. There was tenderness of the midline of bilateral paraspinous regions of the lower lumbar spine. Decreased range of motion with pain was noted. Positive straight leg raise was noted bilaterally. The left was more severe than the right. Sensation was now decreased in the left lateral calf and foot. There was now weakness in the bilateral gastrocnemius and soleus muscles.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division-mandated Official Disability Guidelines, discectomy and laminectomy are recommended when radiculopathy is documented on physical examination and corroborated by imaging and/or electrodiagnostic studies. Serial physical examinations have documented weakness in either the L5 or S1 myotomes, which was sometimes unilateral and sometimes bilateral. The most recent physical examination documented decreased sensation in the left lateral calf and foot; however, there is no documentation of asymmetrical deep tendon reflexes that would indicate a significant radiculopathy. Additionally, the most recent lumbar spine MRI did not document any mass effect or nerve root compromise. The claimant attended approximately seven or eight sessions of physical therapy and failure of a home exercise program was not noted. Failure of medications other than Mobic, Ultracet, Cymbalta, and gabapentin was not indicated. Based on the lack of diagnostic studies corroborating the erratic findings, a possible radiculopathy on physical examination, as well as lack of documentation of an adequate course of conservative treatment, the request for a Lumbar Laminectomy and Discectomy at bilateral L5-S1 is not supported.

ODG -TWC
ODG Treatment
Integrated Treatment/Disability Duration Guidelines

Low Back - Lumbar & Thoracic (Acute & Chronic)

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)

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

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES