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Notice of Independent Review Decision

DATE OF REVIEW: August 29, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L3-S1 decompressive laminectomy and right sided discectomy.

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

M.D., Board Certified in Orthopedic Surgery.

REVIEW OUTCOME

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

- Upheld** (Agree)
- Overturned** (Disagree)
- Partially Overturned** (Agree in part/Disagree in part)

The requested L3-S1 decompressive laminectomy and right sided discectomy is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported a work-related injury on xx/xx/xx as the result of a fall, in which the patient's left shoulder and spine were injured. Due to the failure of initial conservative treatments, the patient received a bilateral hemilaminectomy and foraminotomy at L4-5, with discectomy and eclipse placement. The surgery was performed on 9/10/10, and was noted to improve most of his symptoms; however, the patient continued to complain of right lower extremity pain. According to the documentation submitted for review, the patient began complaining of a significant amount of pain in March 2014. At that time, therapy, massage, pain management, and non-steroidal anti-inflammatory drugs (NSAIDs) were recommended; however, it is unknown if these were obtained. At that time, the patient had decreased muscle

strength in the right dorsiflexor, which was 4-/5. Throughout the follow-up visits, the patient's muscle strength fluctuated from 4/5 to 5/5 in the right quad, right dorsiflexor, right psoas, right extensor hallucis longus (EHL), and right plantar flexor (PF) muscles. It should be noted that the patient's right ankle reflex has remained absent throughout, and has been the primary abnormal reflex. Other than the use of narcotic analgesics, muscle relaxers, and NSAIDs, it is unknown what type of conservative treatment the patient participated in from March 2014 onward. The patient exhibits significant muscle tension throughout, and received trigger point injections on 6/12/14, with recommendation of seven post injection physical therapy visits. It is unknown if these were received. There was also a chiropractic evaluation dated 5/5/14; however, there was no documentation that chiropractic therapy was received. The physical examination performed on 6/17/14 revealed a pain level fluctuating from 7/10 to 8/10, which was always present and worse at night. The patient had decreased muscle strength of 4/5 in the right quadriceps and right dorsiflexor, and absent reflexes in the right knee and right ankle. Additionally, it was noted that the patient's sensation was diminished in unspecified areas of the right leg and right foot. Magnetic resonance imaging (MRI) of the lumbar spine on 4/1/14 revealed no significant canal stenosis at the L1-3 levels or the L5-S1 level. There was a broad-based posterior disc bulge at L3-4, with mild to moderate canal stenosis, but no neural foraminal narrowing. Additionally, the L4-5 level revealed a possible remnant of an annulus, in which the remaining tissue is directly adjacent to the descending right L5 nerve root, with no significant nerve root clumping or compromise identified. There was also no neural foraminal narrowing at that level, or at the level of L5-S1. An electromyography (EMG) dated 4/7/14 revealed a chronic bilateral S1 greater than L5, radiculopathy. The patient's provider recommends L3-S1 decompressive laminectomy and right sided discectomy.

The Carrier indicates in its denial letter dated 7/7/14 that discectomy is indicated in the lumbar spine provided that the patient meets specific criteria, including significant symptomology confirmed by clinical evaluation, imaging studies confirm significant pathology and completion of all conservative treatment. The Carrier further indicates that the submitted MRI revealed no neurocompressive findings at the L5-S1 level; however the electrodiagnostic studies revealed a chronic radiculopathy at the S1 level. Additionally, the Carrier indicates that the request involves a three level procedure which exceeds recommendations. The Carrier indicates that given the conflicting evidence involving the L5-S1 level and taking into account the requested three level procedure exceeding recommendations, the request is not indicated as medically necessary.

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

According to Official Disability Guidelines (ODG) the patient does not meet criteria for a decompressive laminectomies and right discectomies, from L3-S1. According to ODG, patients must exhibit mild to severe unilateral quadriceps weakness or pain, if the L3 level is to be treated; mild to moderate unilateral quadriceps/anterior tibialis weakness or pain, if the L4 level is to be treated; moderate to severe unilateral foot/toe/dorsiflexor weakness or pain, if the L5 level is to be treated; and moderate to severe unilateral buttock/plantar flexor/hamstring weakness or pain, if the S1 level is to be treated. According to the documentation submitted for review, the patient does exhibit unilateral psoas, quadriceps, and dorsiflexor weakness on the right; however, there was no evidence of any consistent foot, toe, plantar flexor/hamstring weakness, or buttock, posterior thigh, or calf pain to correlate with the S1 level. Additionally,

ODG states that imaging studies, such as an MRI, must correlate with the physical examination findings of radiculopathy. According to ODG, there should be evidence of nerve root compression, lateral disc rupture, or lateral recess stenosis at the levels planned to be treated. According to the MRI of the lumbar spine dated 4/1/14, there was no pathology found at the L3-4 level, to include nerve root compression, disc rupture, or recess stenosis. Although there was a suspected remaining annulus at the L4-5 level, there was no evidence of nerve root compression or recess stenosis. Furthermore, at the L5-S1 level, there was no pathology, to include nerve root compression, disc rupture, or recess stenosis. The guidelines also recommend that conservative treatment be exhausted prior to surgical intervention and there should be evidence of activity modification for greater than or equal to two months; failure of drug therapy; and evidence of a support provider referral. While there was evidence of drug therapy failure, there was no specific documentation of activity modification, although the patient was noted to experience pain, possibly indicating that his activities were self-modified. In addition, there was no evidence of a referral to a supporting provider, to include physical therapy, manual therapy, back school, or a psychological screening. Although these modalities were discussed, there was no evidence of these treatments being provided from March 2014 onward when the patient reported a recurrence in his symptoms. Without imaging evidence corroborating physical examination findings and the exhaustion of conservative treatments, the requested surgical intervention is not warranted at this time. In accordance with the above, I have determined that the requested L3-S1 decompressive laminectomy and right sided discectomy is not medically necessary for treatment of the patient's medical condition.

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 JUDGMENT, 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)