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Notice of Independent Review Decision

August 21, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4-5 Laminectomy Discectomy w 1 day los 63030

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

This physician is a Board Certified Orthopedic Surgeon with over 13 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured. She notes that she squatted down and when she got back up she twisted her back. She experienced pain in her lower back, specifically left-sided along the muscle with no central back pain.

Xx/xx/xx: Emergency Room Note. **Musculoskeletal:** Moderate tenderness to palpation along the left lumbar paraspinous area. There is evidence of muscle spasm in this associated region extending to the left buttock. **ER Course:** Patient remained stable throughout the entire ER visit. She was thoroughly evaluated. For her pain, she was given Toradol.60 mg IM as well as Norflex 60mg IM. She noted pain was much improved after about 40 minutes of observation. She was then given Demerol 25 mg IM with Phenergan 25 mg IM. The patient was then deemed stable for discharge. **Assessment/Plan:** 1. Acute lower back pain 2. Muscle spasm Patient was written a prescription for Flexeril 5 mg three times daily p.r.n. for spasm and tramadol 50 mg 1-2 tabs q.8h. p.r.n. for pain. She was advised to follow up with primary care physician for further evaluation and management. She

was advised on continued activity but not to strain or exert herself. She was advised on seeking work limitations. She was advised on seeking physical therapy should this pain persist.

11/15/2013: Office Visit. **HPI:** Patient reports feeling the same. Laying down helps her pain. Denies radiation of pain into legs, denies numbness or paresthesias. She is working regular duty. **Thoracolumbar Spine Motion:** The thoracolumbar spine flexion was abnormal, extension was abnormal, rotation to the left was abnormal, rotation to the right was abnormal, lateral flexion to the left was abnormal, lateral flexion to the right was abnormal, the lumbar/lumbosacral spine exhibited tenderness on palpation of the sacrum-left SI joint, and eueodynamic tests were performed negative SLR bilaterally. No decreased response to pain and temperature stimulation. **Motor Strength:** No knee weakness was observed, no ankle weakness was observed, and no weakness of the toes was observed. No antalgic gait was observed. **Neurological System Reflexes:** The knee jerk was abnormal. The ankle jerk reflex was normal. **Imaging:** An X-Ray of the lumbosacral spine complete, with oblique views was performed 4 views are normal. **Assessment:** 1. Sacroilitis LT **Plan:** 1. Meloxicam 15mg Tablet, take 1 tablet(s) by mouth, every day, for 30 days. Quantity: 30 tablet, no refills. Consultation with a physical therapist DRM **Therapy:** 1. Continue current medications. 2. Follow Up for re-examination in 3 weeks. 3. Fit for work-with restrictions light duty work release.

Xx/xx/xx: Emergency Room Note. **HPI:** Pain radiates into her left hip and left thigh posterior. It is severe. She is out of her medications. She went to see but did not get along with him well and he wanted her to do physical therapy first which she does not agree with. **Physical Examination:** Back: Mild tenderness in lumbosacral area. She does have a positive straight leg raise on the left at about 30° of extension. She has a contralateral positive straight leg raise as well radiating pain down the left lower extremity into the hip and upper thigh area posteriorly. **Extremities:** Neurovascular in the lower extremities is intact. Good pulses. Brisk capillary refill. Sensation is intact. Motor and sensory is intact. Reflexes are 2+. Hip exam was unremarkable, full ROM, no pain with internal or external rotation or grinding. Negative logrolling, etc. **Assessment/Plan:** Acute low back pain. I have discussed the natural history with she and her husband. I will prescribe Norco 5/325 one or two four times daily p.r.n. as she has not obtained relief with her other medications. There will be no refills. I will try to get them an appointment with office.

12/12/2013: Office Visit. **HPI:** Patient reports constant left sided low back pain since injury. Medication helps her pain. Denies radiation of pain into legs. She is working light duty. Pain scale is an 8 today. Denies prior history of lumbar spine injury. Has not yet started PT. **Current Medications:** 1. Tramadol HCl Tramadol 50mg Tablet 1 po qid 2. Meloxicam 15mg 1 tablet qd 3. Cyclobenzaprine hydrochloride Flexeril 5mg tablet 1 po hs **Assessment:** Sacroilitis LT **Plan:** 1. Tramadol HCl Tramadol 50 mg Tablet, take 1 tablet by mouth, up to 4 times a day as needed, for 30 days. Quantity: 120 tablet. 2. Meloxicam 15mg Tablet, take 1 tablet by mouth every day for 30 days. Quantity:30 tablet, no refills. 3.

Cyclobenzaprine hydrochloride Flexeril .5mg Tablet, take 1 tablet by mouth at bedtime as needed for 30 days. Quantity: 30, no refills **Therapy:** 1. Continue current medication 2. Follow-up for re-examination in 3 weeks 3. Fit for work- with restrictions light duty work release.

12/19/2013: Initial Evaluation. **Assessment:** The patient presents to PT with signs and symptoms consistent with diagnosis. She would benefit from skilled PT intervention in order to decrease pain, increase ROM, increase strength, decrease muscle tone, improve posture, and increase functional activity tolerance while developing independence with a HEP. Goals: 1. Patient will report a 50% decrease in pain-3 weeks 2. Patient will report a 50% increase in functional activity tolerance-3 weeks 3. Patient will increase ORM to goal levels (above) in order to facilitate improved tolerance to functional ADLs-3 weeks 5. Patient will present with normal SI alignment/ leg length-3 weeks **Plan:** TIW, 3 weeks

Xx/xx/xx: ER Visit. **Physical Exam:** Musculoskeletal: Normal ROM. She exhibits no edema. Lumbar back: She exhibits tenderness (paralumbal), pain and spasm. She exhibits normal ROM, no bony tenderness and no deformity. Paralumbal spasm and pain +SLR left leg at 30° No midline tenderness. **MDM:** Lumbar radiculopathy: established and worsening **New Prescriptions:** Hydrocodone-acetaminophen (Norco) 10-325 MG per tablet. Take 1-2 tablets by mouth every 4 hours as needed for pain. **Plan:** Schedule an appointment as soon as possible for a visit.

01/21/2014: Office Visit. **HPI:** Pt is feeling the same. She has not started PT yet. She was seen xx/xx/xx due to her pain and was prescribed Hydrocodone 10/325mg. **Plan:** Patient has not been compliant with treatment as she has not started PT, insist on being taken off of work. She also insists on prescription for narcotics. These are all counter to my recommendations and I feel like it is in everyone's best interest that this patient find another treating. I will provide her with hand delivered letter terminating treatment in 15 days from today.

01/22/2014: X-Ray Report. **Impression:** This is supposed to be a 2 view thoracic spine but actually it is a 2 view lumbar spine. There is nothing showing of the thoracic spine that is worth mentioning. The 2 view lumbar AP and lateral show good alignment of the vertebral bodies. The disc spaces are well maintained. No obvious osseous problem in the lumbar spine.

01/24/2014: Initial Visit. **HPI:** Patient is no longer seeing and wants us to take over her care. Patient is not sleeping well. She is still working under restriction and states it is very difficult. **Lab:** UDS is positive for benzodiazepines and TCA and was sent out for confirmation. **Current Medications:** 1. Tramadol 2. Flexeril 3. Meloxicam **Physical Examination:** Patient denies any palpatory tenderness but does complain of muscle spasms in the lumbar spine as well as decreased ROM in the lumbar spine due to pain at end range. Patient is rate tender to palpation of the L4-5 and L5-S1 articulations. S1 dermatome sensation losses noted on the right compared to left. Reflexive zones and myotomes are without gross deficit. Straight leg raise is positive for pain right more than left. **Diagnosis:** 1. Radicular

pain into legs 2. Sprain/strain, lumbar. **Treatment/Plan:** 1. Medications: a. Reviewed pain management agreement with patient who verbalized understanding b. I discussed with her the risks of benzodiazepines associated with the pain medication and especially the danger at night c. I will discontinue Tramadol d. Will continue Flexeril and meloxicam e. Will add Norco 5/325 mg t.i.d. 2. Diagnostics: a. We did an x-ray of the lumbar spine today in office for review. b. recommend lumbar MRI due to continued pain coupled with radicular complaints and extended date of injury being November. Work Status: a. DWC-73 was completed with work restrictions. I do not want her lifting anything over 1-lb No kneeling, bending, stooping, pushing or pulling. She is going to be taking prescription medication, which could affect her and make her drowsy. 4. Follow up in 2 weeks.

02/05/2014: MRI Lumbar Spine Without Contrast interpreted **Impression:** 1. A moderate left-sided disc extrusion is present at L4-L5. Disc material abuts and deforms the thecal sac in the region of the left L5 root exit zone. 2. No evidence of disc protrusion, central narrowing or neural foraminal narrowing at the remaining lumbar levels. 3. MRI lumbar spine otherwise unremarkable.

02/07/2014: Recheck Visit. **HPI:** Patient indicates no change in condition at this time with medication providing little analgesic effect. **Physical Examination:** Active ROM of lumbar spine remains decreased in flexion and extension and flexion maneuvers provocative for left lower leg pain. L6/S1 dermatome sensation losses noted on the left. Reflexive zones and myotomes are without gross deficit. Straight leg raise is positive for pain in the right lower extremity compared to left. **Imaging:** A moderate left-sided disc extrusion is present at L4-L5. Disc material abuts and deforms the thecal sac in the region of the left L5 root exit zone. **Diagnosis:** 1. Lumbar disc extrusion 2. Lumbar Radiculitis versus radiculopathy **Treatment Plan:** 1. Continue medications as directed 2. Recommend electrodiagnostics of the bilateral lower extremities to confirm or deny radiculopathy. Recommend consultation 3. Consider interventional procedures following results of #2 4. Work Status: a. DWWC-73 was completed with work restrictions. I do not want her lifting anything over 10lb. No kneeling, bending, stopping, pushing or pulling. She is going to be taking prescription medication, which could affect her and make her drowsy. 5. Follow up with the patient in two weeks.

02/10/2014: Lab Report. **Summary of Findings:** Patient Specimen has: Inconsistent results, Analyte detected but no corresponding prescription reported Detected Analyte: Oxazepam

02/28/2014: Patient Evaluation. **Subjective:** Patient reports she has not undergone therapy for her injuries. She states she is scheduled for a DDE next week. She was returned to work sedentary duty, employer could not accommodate the restrictions therefore she is off work. **HPI:** Symptoms/related: Reports symptoms of numbness/tingling to the LLE Musculoskeletal (BJE): Reports symptoms of back pain (lower or lumbar-sacral), leg/thigh pain or problems Lumbar: Left low lumbar paraspinals are tender with palpation, right are

non-tender. Positive SLR on the left, right SLR causes cross over pain. Hip: Left SI joint is tender with palpation. Right SI joint is non tender with palpation. Bilateral piriformis is non tender with palpation. Bilateral Ischial are non-tender with palpation. Bilateral ITB is non tender with palpation. ROM: Forward flexion is noted at 25° with increased pain. Extension is noted at 10° with increased pain. Right and left lateral flexion is noted at 25°. Muscles: Normal muscle strength and tone are found. Neurological: Reflexes: deep tendon reflexes are intact bilaterally Sensation: Sensation to light touch intact to the BLE **Assessment:** Lumbosacral Radiculitis NOS ICD#724.4, Lumbar sprain/strain ICD#847.2, Sacrolitis ICD#720.2, Lumbar disc herniation without cord compression ICD#722.10, Accident while engaged in work related activity ICD#E928.9 11/11/2013 **Plan:** Preauthorize then schedule bilateral EMG/NCV studies. Continue care.

03/31/2014: Caudal Epidural Injection. **Postoperative Diagnosis:** Lumbar Radiculitis. **Procedure:** Lumbar epidural injection with confirmatory epidurography under fluoroscopic assistance.

04/16/2014: Office Visit. **History:** Patient underwent lumbar intralaminar epidural steroid injection 2 weeks prior and is reporting 40% reduction in pain. **Physical Examination:** Active ROM of lumbar spine remains decreased in flexion and extension and flexion. Tenderness is noted over the L4-5 and L5-S1 articulations with reflexive spasms. Neurologically patient seems intact. Mild pain with straight leg raise. **Imaging:** A moderate left-sided disc extrusion is present at L4-L5. Disc material abuts and deforms the thecal sac in the region of the left L5 root exit zone. **Diagnosis:** 1. Lumbar disc extrusion 2. Lumbar radiculitis versus radiculopathy. **Treatment Plan:** 1. Patient recommended for 6 additional visits of spine stabilization PT. To be scheduled pending preauthorization. 2. Continue medications as directed 3. Continue work restrictions 4. Follow up with the patient in two weeks

05/16/2014: XR L Spine Come + Flex/Ext. **Impression:** There is mild loss in disc stature at L4-L5. No fracture or spondylolisthesis is demonstrated. There is no pathologic motion of the lumbar spine with flexion and extension.

05/20/2014: Office Visit. **HPI:** The patient is experiencing burning, numbness and tingling into her left leg. She has tried chiropractic, physical therapy, injections and medications; however she continues to have pain. She has been unable to work since February 2014 because of her injury. Her symptoms are progressively getting worse. She is having difficulty sitting, standing, walking, rising from a chair and physical activity. Her pain is worse at night and wakes her from sleep. She presents today for further evaluation and discuss what her treatment options are at this point. **Past surgeries:** C-section 99-01-04, Right shoulder 4-13. **General Appearance:** Good ROM to all joints in upper and lower extremities. No edema seen. Good peripheral pulses present. Neurological Exam: Cranial nerves 2-12 are grossly intact. Upper and lower extremity deep tendon reflexes are equal and symmetric and a grade 2 out of 4. No long tract signs are seen. Negative Romberg's sign. Negative Hoffman's sign. Negative Babinski's. Negative reverse radial reflex. Demonstrate a normal gait pattern. Motor Exam: Upper and lower

extremity motor strength grade testing is a 5 out of 5. **Spinal Examination:** Patient stands with an erect posture. They demonstrate a normal gait pattern. Negative for pelvic obliquity. There is significant spinal tenderness in the paraspinal muscles. Bilateral straight leg raise is positive. There are no Waddell sign's present. There is normal sensation to light touch seen in both upper and lower extremities. There is normal motor strength to upper and lower extremities. Reflexes in upper and lower extremities are normal at 2 out of 4. There is a negative Spurlings test and negative Lhermitte's sign. No long tract signs are present. The patient demonstrates poor ROM with flexion, extension, side bending and rotation. Spinal motion is with pain. **Radiology/Imaging Review:** X-Ray performed in office today. AP, lateral, Flexion and extension views of the lumbar spine demonstrate 5 mobile Lumbar segments. Pedicles are well visualized. Normal appearance to the Sacroiliac joints. Normal appearing Vertebral bodies. There is no instability seen. There is a normal appearance to the discs except for disc space narrowing at L4-5 MRI review: Radiologist findings noted with the following modifications Large extruded herniated nucleus pulposis, left side L4-5 **Assessment:** Patient has low back pain and left lower extremity pain with radiculopathy secondary to large extruded herniated nucleus pulposis, L4-5, left side. **Plan:** At this point patient has failed conservative treatment consisting of physical therapy, chiropractic therapy, injections, medication management. She is currently not working and will be unable to return to work until she has surgery for a laminectomy discectomy at L4-5. We will go ahead and keep her off work until then. We'll set her up for surgery. I will see her back for preop teaching prior to surgery. **New Medications:** Zanaflex tabs, Hydrocodone-acetaminophen tabs

06/17/2014: UR . **Rational for Denial:** ODG-Treatment in Workers' Compensation requires there be objective findings of radiculopathy corroborated by imaging studies and/or electro diagnostic testing. The most recent physical examination documented bilateral positive straight leg raise testing however the MRI documented only left-sided possible nerve root involvement. Sensation, motor strength, and deep tendon reflexes were normal and symmetric in the lower extremities. The records do not reflect failure of lower levels of care including documentation of the amount of chiropractic care to date or failure of a home exercise program. There is no documentation of failure of non-steroidal anti-inflammatories in the claimant. The request for an L4-L5 laminectomy discectomy is not certified.

06/30/2014: UR. **Rational for Denial:** This is a non-certification of an appeal of an L4-L5 laminectomy discectomy with a one day length of stay. The previous non-certification on June 17, 2014, was due to lack of objective evidence of radiculopathy on the MRI corroborating with the physical examination and lack of documentation of failure of lower levels of care. The previous non-certification is supported. Additional records were not provided for review. ODG- Treatment in Workers' Compensation requires objective evidence of radiculopathy. The claimant has a normal neurological evaluation. The records do not reflect lower levels of care have been exhausted such as use of non-steroidal anti-inflammatories or a home exercise program. The records do not reflect the

amount of previous chiropractic care, physical therapy, or epidural steroid injections. The request for an appeal of an L4-L5 laminectomy discectomy with a one day length of stay is non-certified.

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

The previous adverse determinations are upheld. The Official Disability Guidelines (ODG) supports Discectomy Laminectomy for the treatment of lumbar radiculopathy associated with disc disease. The physical examination should correlate with compression of a specific nerve root. The imaging studies must support the examination findings. The patient should complete a full course of conservative care prior to consideration of surgery. The patient currently complains of pain in the left leg. Her most recent physical examination demonstrates a positive straight leg raise, bilaterally. She has no evidence of weakness, numbness, or abnormal reflexes. Although the lumbar spine MRI demonstrates a left sided disc herniation at L4-5, the physical examination does not correlate with compression of a specific nerve root. It is unclear why the patient has a positive straight leg raise sign in both legs, in the setting of a left-sided disc herniation. In addition, she had incomplete pain relief following the epidural steroid injection. In this case, electrodiagnostic testing (EMG/NC) is required to confirm the diagnosis of radiculopathy associated with the L4-5 herniated disc, prior to any lumbar surgery. For these reasons, L4-5 Laminectomy Discectomy w 1 day los 63030 is not medically necessary.

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)

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)**