MedHealth **R**eview, **I**nc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

DATE NOTICE SENT TO ALL PARTIES: 8/16/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of an outpatient lumbar spine, L3-5 decompression and bilateral L5 facetectomies.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Neurological Surgery. The reviewer has been practicing for greater than 10 years.

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 reviewer agrees with the previous adverse determination regarding the prospective medical necessity of an outpatient lumbar spine, L3-5 decompression and bilateral L5 facetectomies.

PATIENT CLINICAL HISTORY [SUMMARY]:
This is a XXXX who sustained an injury on XXXX. XXXX was XXXX. XXXX felt sudden onset of back pain. The patient was seen by multiple providers. Based on the notes, it does look like XXXX has had physical therapy as well as injection therapy to treat the symptoms. The specific therapy and number of visits are not clearly delineated. These did not result in significant relief of symptoms. The MRI of the lumbar spine from XXXX shows post op laminectomy changes on the right at L5-S1, foraminal stenosis L3-S1, moderate central canal narrowing at L4-L5, less prominently at L2-L3 and L3-L4. There is also epidural lipomatosis.

The patient was seen by XXXX. The patient reported a "great deal" of axial lower back pain bilaterally. XXXX denied symptoms of neurogenic claudication. XXXX was reported to have treated with nearly all conservative modalities available. The specific treatment with physical therapy and duration are not documented. The documented examination identified the patient as having 5/5 strength in all left lower extremity movements. There was limitation of the exam in the right lower extremity in most movements because of pain. The specific codes for the visit identified lumbar radicular pain and lumbar stenosis without neurogenic claudication. XXXX was also seen on the same day by XXXX. XXXX note documents that the patient has symptoms of claudication and radiculopathy. No examination is included with this evaluation. XXXX recommended an L3-L5 lumbar decompression for the purpose of decompressing the epidural lipomatosis. XXXX also recommended performing bilateral medial facetectomies at L5 for the purpose of decompressing the exiting L5 nerve roots.

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

The official disability guidelines were used for determination of necessity of this procedure. ODG Indications for Surgery™ -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; and 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. MRI (magnetic resonance imaging)
   2. CT (computed tomography) scanning
   3. Myelography
   4. CT myelography and 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)

The notes do not confirm the presence of objective findings on examination. The note from the XXXX reported right leg weakness in most movements but did not specifically identify the dermatome that could be correlated with the imaging. There is no documentation of any atrophy. There is no documentation of a straight leg raise test, cross straight leg raise test or any reflex abnormalities. The documentation by XXXX does not identify the symptoms that XXXX would relate to being neurogenic claudication as XXXX note contradicts XXXX note from the same day. XXXX does not identify a specific dermatome for the radiculopathy. There is no documentation of bilateral symptoms as would be present if the patient had neurogenic claudication resulting from spinal stenosis. The guidelines for laminectomy and facetectomy require objective evidence of nerve root compression with correlating dermatomal findings on clinical exam. All the criteria have not been met; therefore, the procedure is not medically necessary based upon the records provided.

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 GUIDELINE**

☐ **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)**