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Date notice sent to all parties: 05/30/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Laminotomy with decompression bilaterally at L4-L5 and laminectomy and foraminotomy bilaterally at L4-L5

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Orthopedic Surgery

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

X Upheld (Agree)

☐ Overturned (Disagree)

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

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Laminotomy with decompression bilaterally at L4-L5 and laminectomy and foraminotomy bilaterally at L4-L5 - Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

A lumbar MRI dated XXXX showed small disc herniations at L3-L4 and L5-L5. An EMG/NCV study on XXXX revealed mild left greater than right C5 nerve root irritation and bilateral L5 radiculopathy on the right greater than left. The impressions included disc herniations at L3-L4 and L4-L5 and disc bulges at L2-L3 and disc bulges at C3-C4, C4-C5, and C5-C6 with contact at the cord at C5-C6. Per a Benefit Dispute Agreement dated XXXX, the parties agreed the injury extended to and included cervical disc bulges at C3-C4, C4-C5, and C5-C6, as well as disc herniations at L3-L4 and L4-L5. A lumbar CT myelogram dated XXXX revealed disc space narrowing and a 2.5 mm anterior epidural impression at L3-L4 and a 2 mm. anterior epidural impression at L4-L5. On XXXX, a XXXX noted XXXX reported the XXXX and XXXX was now in pain rated at 7/10. In a managed care clinic note of XXXX, XXXX was involved in an XXXX and XX and XX, which XXXX was already taking, was continued. XXXX examined the patient on XXXX. XXXX had low back pain with radiated to XXXX left leg with numbness and tingling. XXXX had an injection shortly after the XXXX, but no treatment since them. XXXX was XXXX and not working. XXXX was XXXX and current every day smoker. XXXX now claimed progressive problems with ambulation, numbness, and tingling in all 4 extremities. XXXX had diabetes and neuropathy. XXXX had a wide based gait with the use of a cane on exam and XXXX had no gross motor deficits in the seated position. DTRs were preserved at the knees and 3 at the ankles.

XXXX had an inverted radial reflex and a Hoffman's sign, which could be associated with an upper normal motor neuron disease. Physical therapy and x-rays were recommended. XX was prescribed. Lumbar MRI dated XXXX revealed multilevel degenerative disc disease and facet arthropathy with superimposed left sided foraminal/extraforaminal protrusions at L2-L3 and L3-L4. These factors combined to produce multilevel canal and foraminal stenoses. On XXXX, the cervical MRI was reviewed. An ACDF at C4-C5 was recommended and the patient was discharged on XXXX post interbody fusion at C4-C5 and C5-C6. The patient then attended therapy through XXXX and followed-up with XXXX on XXXX. XXXX had low back pain that radiated to the right and left buttock down to XXXX feet when XXXX walked, on the right greater than the left. The MRI was noted to show severe stenosis at L4-L5, but no instability. On exam, XXXX had positive SLR and weakness of both legs. The EHL and dorsiflexor was 4+ on the left versus 4-/5 on the right. The assessment was lumbar spinal stenosis. XXXX recommended bilateral laminectomies and foraminotomies. On XXXX, a denial was provided for the requested lumbar surgery. On XXXX, XXXX reevaluated the patient, noting the surgery had been denied. XXXX walked with a cane in a bent over posture. XXXX had spasms to XXXX back and no reflexes at XXXX ankles. XXXX had no gross strength deficits, but SLR was positive bilaterally. Bilateral L4-L5 decompressive laminotomy and foraminotomies were recommended. On XXXX, another denial was provided for the requested laminotomy with decompression bilaterally at L4-L5 and laminectomy and foraminotomy bilaterally at L4-L5.

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

The MRI scan of XXXX does not document any neurological compression nor does CT myelogram of XXXX. The MRI scan that was obtained on XXXX showed degenerative changes consistent with the patient's date of birth of XXXX. These degenerative changes showed canal stenosis and bilateral foraminal stenosis. However, there is no information in XXXX or PA XXXX records to implicate that the patient has objective evidence of radiculopathy. XXXX also has a neuropathic process based on the records reviewed and there are not any specific findings to implicate the L4-L5 level. Based upon the documentation reviewed, I concur with the prior reviewers that the Official Disability Guidelines (ODG) require a clinical correlation from the history, symptoms, radiological findings, and the planned intervention. In this case, there is a mismatch and surgery would be neither reasonable nor necessary. Therefore, the requested lumbar laminotomy with decompression bilaterally at L4-L5 and laminectomy and foraminotomy bilaterally at L4-L5 is not appropriate, in accordance with the ODG, or medically necessary and the previous adverse determinations should be upheld at this time.

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**

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

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X 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)**