DATE OF REVIEW: 09/28/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
XX XX hemi-laminectomy XX-XX

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:

☒Upheld (Agree)

☐Overturned (Disagree)

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

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute:

- XX XX hemi-laminectomy XX-XX - Upheld.

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX saw the claimant for XX hip pain. The claimant is XXXX. The claimant had no prior problems with the XX hip. The claimant was XXXX. Exam revealed a severe limp, tender to palpation over the XX greater trochanter with mild swelling. Distally neurocirculatory was intact, satisfactory motion of the hip without any XX pain. X-rays XX XX and XX and XX of the XX hip was negative. The diagnosis was XX XX XX and an injection was performed.

XXXX saw the claimant on XXXX for sever XX hip pain and now having pain that started in the buttock and radiated down the leg with low XX pain. Exam revealed a strong positive straight leg raise on the XX. XX x-rays revealed XX-XX XX space narrowing. MRI of the XX hip and XX XX ordered.

MRI of the XX hip dated XXXX identified no significant abnormality and no internal derangement.

MRI of the XX XX dated XXXX revealed at XX-XX mild neural XX stenosis due to XX arthropathy / ligamentous hypertrophy. At XX-XX mild to moderate XX neural XX stenosis due to XX protrusion / XX and XX XX / XX. XX XX may abut the XX XX nerve root in the XX / extraforaminal region. Findings noted desiccation at XX-XX and XX-XX and mild to moderate XX joint arthropathy and ligamentous hypertrophy. There were XX changes affecting the inferior endplate of XX and superior endplate of XX.

On XXXX saw the claimant for XX hip pain that started in the XX and radiated down to the XX and down the XX. There was no weakness. The MRIs were reviewed, and XX MRI revealed XX stenosis at XX to XX and the XX hip MRI was normal. XXXX was ordered and the claimant was referred to neurosurgery.

XXXX saw the claimant on XXXX for low XX pain after getting up to address a patient. The claimant developed some pain in the XX and over the XX greater XX area and felt like there was some swelling over that area and difficulty with walking. Several days after the incident, the claimant developed some low XX pain and into the XX buttocks and felt like there was some tingling over the XX XX leg. The pain did not radiate below the knee and there was no weakness or numbness into the feet. XX XX exam revealed XX tenderness, XX tenderness on the XX, no pain to straight leg raise, negative femoral stretch test, no weakness, negative XX. Sensation was normal from XX through XX. Motor function was normal. Reflexes were intact and symmetrical in the knees and ankles. Range of motion of the hips was intact. There was XX tenderness and XX IT band tenderness. The claimant had XX XX pain. X-rays of the XX XX from XXXX showed degenerative changes at XX to XX, and XX degenerative changes. The XX MRI showed minimal XX desiccation at XX-XX and XX-XX and XX were patent to the XX and XX. At XX-XX, there was mild XX recess narrowing XX greater than XX and early XX at XX-XX. There was small XX at XX-XX. XX-XX showed mild XX desiccation with mild XX XX component. XX flexion/extension x-rays on this date with flexion/extension views showed no instabilities. There were mild degenerative changes at XX-XX. The MRI of the XX was reviewed with the radiologist and there were mild degenerative changes at XX-XX but no specific neural canal compromise. Diagnosis was other intervertebral XX degeneration, XX region with no XX radiculopathy and probable XX XX versus external rotator strain with XX XX hip. XXXX opined that the claimant most likely hurt something in the short external rotators that were over the greater XX region and ITB with localized swelling within that region that resolved and remained with pain and then developed low XX pain which was a secondary problem. The neurologic exam remained intact and based on the radiographs and MRI findings, this would most likely respond with conservative treatment. Recommended therapy for the XX hip and lower XX. Medications were prescribed.

On XXXX saw the claimant for a follow up and the pain continued in the XX XX and over the greater XX region of the XX hip. The claimant had some intermittent pain of the low XX but the pain that bothered XXXX the most was over the XX hip. The claimant had completed XX and had done therapy for the XX hip. The claimant denied any pain that radiated further down into the leg and had no new numbness or weakness in the leg. The XX exam was the same as on the

prior exam. Diagnosis was XX hip XX and other XX-XX. The XX hip was injected and additional PT was ordered.

XXXX saw the claimant on XXXX for follow up who reported that therapy was aggravating the XX hip pain. XXXX reported that there were degenerative changes in the lower XX and the claimant had some mild pain above the sternal side of the lower XX and mildly into the XX buttocks but the main complaint continued to be tenderness and pain over the greater XX region of the XX hip and pain into the XX XX that was reproduced with range of motion of the XX hip. XXXX felt that the predominance of the pain was more from the XX hp and not the lower XX. The claimant had tried medicine and therapy for the lower XX that did not give the claimant any relief. The claimant was referred to a hip specialist.

On XXXX, XXXX performed XX hip XX with XX and XX and XX hip arthroscopic XX bursectomy. The postoperative diagnosis was XX hip XX (XX type); XX labral tear and XX XX XX.

MRI of the XX hip with contrast dated XXXX identified evidence of prior labral repair with no distinct MRI evidence of a recurrent injury. There was mild chondral thinning in the XXaspect of the XX hip. There was mild tendinosis of the distal XX XX. There was minimal XX greater XX XX.

On XXXX, XXXX saw the claimant who reported the pain was improved compared to before surgery though there was continued XX pain, stiffness, and inflammation about the hip. The claimant denied numbness, tingling, fever or calf pain. The pain was getting worse and there was occasional popping. The claimant had pain and mechanical symptoms likely secondary to postoperative inflammation and synovitis and was to continue therapy.

XXXX saw the claimant on XXXX for a designated doctor exam and opined that the claimant had not reached MMI. The claimant indicated XXXX was scheduled for an EMG and that the doctors did not know what was wrong with XXXX and XXXX, also did not have an opinion as to what was wrong either. The claimant indicated XXXX liked XXXX job and that the pain levels with walking and sitting was interfering with the ability to work in a sedentary position. The claimant complained of acute sharp pain over the femur head areas. Thee was moderate pain in the posterior gluteal area, XX area, and XX and XX thigh areas. There was a systemic weakness of the XX leg with loss of range of motion. On exam, there was an antalgic gait and movements were only guarded around the XX femur head. Palpation of the XX XX revealed marked tenderness of the XX joints and vertebrae compression elicited pain on XX through XX. Palpation of the XX greater XX, pubic bones and superior femur medially were tender and reactive with pain. Most of the muscles controlled by the femoral and obturator nerves were painful at their origin and insertions. Palpation of the sacral base posterior revealed marked tenderness of the muscles. The claimant had a past medical history of low XX problems. On exam, the claimant could not perform XX hip abduction due to pain with spasms. Reflexes were 0 at XX patella and XX of XX Achilles and 0 of XX Achilles. XX thigh was 43 and XX was 42; calf was 33 on XX and 35 on XX. Diagnosis was XX hip labral tear per treating doctors and insurance carrier. Also radiculopathy from XX XX per treating doctors and DD doctor. For the accepted XX hip labral tear, the case had proved to be complicated for the treating physicians

and while the symptoms of severe pain, severe swelling of the acetabulum, weakness and loss of motion in the hip and low XX had made some improvement, the claimant professed marginal improvement in symptoms. While the XX labral tear was missed by the first few doctors and its repair had been achieved, the claimant had been unable to return to normal duties. The DD opined that there were additional injuries on display and the pain pattern was following the femoral and obturator nerves and was likely XX in derivative. The DD opined that while the obvious might be XX and XX stenosis, thee was possible contributions from the XX and XX XX areas as well. The treating doctor wanted to do an EMG and this was a good start, especially related to the middle to upper XX XX. Due to lack of recovery and radiculopathy, the claimant was not at MMI.

On XXXX performed an EMG/NC of the XX lower extremity that was normal.

XXXX saw the claimant on XXXX for continued pain in the XX lower XX and mostly over the greater XX region of the XX hip and down into the XX XX. The claimant had some pain radiating down the side of the leg but felt that all the pain was proximal to the knee and now distal. The claimant felt that XXXX had to lie down on the XX side with two pillows between the legs to have any relief. XX exam revealed tenderness to palpation, no XX tenderness, no pain to straight leg raise, negative femoral stretch test. There was weakness. Sensation was normal from XX through XX. Motor exam revealed normal in the hip flexors, knee extensors. XX ankle dorsiflexors were XX/XX; XX/XX on the XX. Reflexes were intact at knees and ankles. There was tenderness and pain with motion of the XX hip and there was XX XX tenderness. There was breakaway weakness of the XX lower extremity. X-ray of the XX XX with flexion/extension showed degenerative change at XX-XX and mildly at XX-XX. Diagnosis was other intervertebral XX degeneration, XX-XX without XX radiculopathy; XX hip XX and history of XX hip scope with continued XX hip symptoms. The possible etiology of the pain was discussed and XXXX reported that the claimant had some mild pain that bothered XXXX in the XX side of the lower XX as well as pain that radiated down into the XX leg but most of the pain was reproduced with motion of the XX hip and tenderness over the greater trochanter of the XX hip. XXXX was prescribed and a new XX MRI was ordered for a definitive diagnosis. The claimant may need further workup with the hip specialist if the pain continued to be predominantly associated with the XX hip.

MRI of the XX XX dated XXXX read by XXXX, compared to plain films, showed mild symmetrical XX bulging at XX-XX and no other significant abnormality. Findings noted mild decrease in discal hydration was present. There was mild symmetrical bulging of the XX seen at XX-XX, extending posteriorly for approximately XXmm. No XX or XX stenosis was appreciated.

XXXX saw the claimant on XXXX for a follow up evaluation. The claimant had the XX MRI and returned to discuss treatment options. The exam findings were the same as noted by XXXX on XXXX. The XX MRI showed degenerative change at XX-XX and XX-XX. XX were patent. XX-XX showed small XX paracentral protrusion compressing the XX XX nerve root. Radiologist did not note the XX at XX-XX off to the XX. Dx: XX XX at XX-XX not noted by the radiologist, compressing the XX XX nerve root and consistent with low XX pain and radiculopathy; XX hip XX with history of XX sided hip scope and XX hip symptoms. The

claimant had a very small XX herniation off to the XX at XX-XX but just in the area that it would compress the nerve root and cause symptoms into the leg. Surgery would include microdiscectomy at XX-XX to the XX. The claimant would like to try an injection.

On XXXX, XXXX saw the claimant referred by XXXX for low XX and XX lower extremity pain. The claimant reported symptoms were pain, muscle spasm and swelling at the pain site. The claimant denied distal numbness and weakness of the limbs. The pain was 8 to 9 currently. The claimant was XXXX. Exam revealed the claimant was XXXX and in mild distress. The claimant transferred from sitting to the exam table without difficulty. Pinprick sensation was decreased to the XX XX into the kneecap area and down to the inside ankle region; strength was normal except XX-/XX of XX XX tibialis; reflexes XX+ of XX patellar, XX+ of XX patella; Achilles were XX/XX. Straight leg raise on the XX was positive for radiating leg pain. The provider noted that the MRI findings were consistent with multilevel pathology though the exact source for pain was ambiguous. XX XX and XX selective nerve root block ordered.

On XXXX performed fluoroscopically guided needle localization of the XX XX and XX XX nerves with transforaminal epidurograms and epidural injection of local anesthetic and steroid.

On XXXX saw the claimant who reported no relief with the injection and had the same pain ongoing since XXXX. Exam revealed tenderness to palpation on the XX, XX tenderness on the XX, no pain to straight leg raise, negative femoral stretch, normal sensation XX through XX. Motor exam was normal. Reflexes were intact and symmetrical in the knees and ankles. There was mild tenderness with motion of the XX hip and XX greater XX tenderness. Diagnosis was other intervertebral XX degeneration, XX region. XXXX noted that the impression was XX paracentral protrusion XX-XX noted by the radiologist compressing the XX XX nerve root consistent with low XX pain and radiculopathy; XX hip XX and history of XX sided scope and symptomatology. XXXX discussed that the XX XX-XX protrusion that impinged the nerve caused some of the radicular pain to radiated down the XX leg and some of the pain originated from the XX hip. The claimant would like to proceed with surgery and the plan was for a XX hemilaminectomy XX-XX and it was discussed that this may still not resolve all of the pain in the XX hip.

Utilization review provided adverse determination on XXXX for XX XX hemilaminectomy XX-XX. Peer to peer contact noted that XXXX indicated that the MRI report missed the XX herniation at XX-XX and that the claimant had neurological deficits on the physical exam. At the time of submission, there were no additional records provided that would support altering the determination.

On XXXX submitted a report regarding the denial and noted that the reviewing physician did not ask for further documentation or a revised MRI report. XXXX reported that the MRI was re-rear by an outside physician who noted the XX herniation to the XX at XX-XX that was consistent with the symptoms that was discussed with the peer review physician and that the initial reading radiologist had missed.

There was a one page addendum report signed by XXXX and noted “A small XX x XX mm XX XX XX extrusion was noted at XX-XX.”

Utilization review provided an appeal request denial on XXXX noting that there was lack of actual documentation of failed therapy and there was no pain to a straight leg raise.

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

The claimant is a XXXX who reported feeling a pop in the XX hip with swelling XXXX. Records indicate the claimant is XXXX. An initial XX MRI on XXXX revealed desiccation at XX-XX and XX-XX and mild to moderate XX joint XX and ligamentous hypertrophy. There were Modic type I degenerative endplate changes affecting the inferior endplate of XX and superior endplate of XX. The treating orthopedic surgeon diagnosed mild degenerative changes at XX-XX but no specific neural canal compromise. The claimant had a XX hip surgery that revealed XX hip XX (XX type); anterosuperior acetabular labral tear and recalcitrant XX XX. The claimant had a normal EMG/NC of the XX lower extremity in XXXX. After failure to improve after the XX hip surgery, a repeat XX MRI was performed on XXXX with the radiologist reporting findings of mild bulging at XX-XX and no central canal or XX stenosis being appreciated. On XXXX, a provider reviewed the imaging and reported that this MRI also revealed a very small XX herniation off to the XX at XX-XX with compression of the nerve root. The claimant underwent a diagnostic selective nerve root block on XXXX of the XX XX and XX XX nerves with no improvement in symptoms. The exam findings by the treating surgeon on XXXX revealed a negative femoral stretch, normal sensation from XX through XX, normal motor exam and intact and symmetrical reflexes in the knees and ankles. The treating orthopedic surgeon identified XX tenderness on the XX, mild tenderness with motion of the XX hip and XX greater XX tenderness.

The treating surgeon has diagnosed a XX paracentral protrusion at XX-XX that was compressing the XX XX nerve root consistent with low XX pain and radiculopathy. On XXXX, there was a one page addendum to the XXXX XX MRI, noting a finding of a small XX x XXmm XX XX XX extrusion at XX-XX. That addendum report did not identify nerve root compression. The clinical exam findings, in particular the negative femoral stretch on the XX and the symmetrical and normal patellar reflex do not identify objective evidence of compression of the XX XX nerve root. There was no atrophy. There was no severe unilateral quadriceps or XX tibialis strength loss. The selective nerve root injection of the XX XX and XX nerve roots that was performed to help determine pain generators when physical signs and symptoms differ from those found on imaging did not improve the claimant's symptoms. The claimant had a negative EMG/NC of the XX lower extremity on XXXX.

As there is no objective evidence of a XX XX or XX radiculopathy on physical exam or the EMG/NC and no evidence of nerve root compression on the XX MRIs performed to date, the proposed XX XX XX XX-XX is not medically necessary per evidence based medicine guidelines, including the ODG.

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

☒ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☒ **ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**