

# C-IRO, Inc.

An Independent Review Organization  
7301 Ranch Rd 620 N, Suite 155-199  
Austin, TX 78726

## DATE OF REVIEW:

JULY 24, 2007

## IRO CASE #:

## DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Posterior laminectomy L4-S1 with two day inpatient stay

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

M.D., Board Certified Orthopedic Surgeon

## 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.

## INFORMATION PROVIDED TO THE IRO FOR REVIEW

Lumbar spine MRI without contrast, 02/01/07  
EMG/NCV, 02/08/07 and 06/26/07  
Office notes, Dr., 03/01/07, 04/24/07 and 06/12/07  
Lumbar injection operative reports, 03/14/07, 03/28/07 and 04/18/07  
Designated Doctor's evaluation, Dr., 05/19/07  
Adverse determination letter, 05/25/07  
Insurance form, 06/04/07  
Consultation, Dr., 07/1/107  
Authorization request for posterior lumbar laminectomy with a two-day admission

## PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male maintenance worker who reported low back pain after lifting an 8 gallon container of water. An MRI of the lumbar spine showed disc protrusions at L4-5 and L5-S1 with canal stenosis and mild bilateral neural foraminal narrowing. An EMG/NCV study showed chronic L4 radicular changes on the right side. Dr. examined the claimant on 03/01/07 with findings of 1+ deep tendon reflexes distally, tenderness in the lumbar musculature, decreased range of motion and positive straight leg raise on the right. The claimant continued to complain of low back pain and right lower extremity pain, weakness, numbness and tingling. He treated with temporary total disability work status, medications, physical therapy and three epidural steroid injections without lasting benefit. Diagnosis of disc protrusions at L4-5 and L5-S1 causing foraminal stenosis, lumbar radiculopathy and low back pain were documented. Examination by Dr. on 06/12/07 found 5/5 strength in all muscles tested except the left hip flexor at 4/5 strength and left hamstring at 5-/5 strength. Sensory was intact to light touch. A repeat EMG/NCV on 06/26/07 found electrical diagnostic evidence for a right L4 and L5 chronic lumbar radiculopathy. A consultation by Dr. on 07/11/07 noted complaints of low back pain with radiation into the right lower extremity along the lateral thigh and calf especially into the lateral aspect of the right ankle, with numbness and tingling in a similar distribution. Dr. noted positive right straight leg raise test, 5/5 muscle strength except in the right extensor hallucis longus and ankle dorsiflexors. Sensation was decreased in the right lower extremity in a non-dermatomal distribution. Reflexes were 1+ in the left lower extremity and 1+ in the right lower extremity. A request was made for authorization of a posterior lumbar laminectomy from L4 to S1 with a two day inpatient admission.

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

The claimant is a male for whom request has been made to perform a lumbar laminectomy at L4 through S1.

Records reflect this gentleman reportedly injured his back. Subsequently he developed pain complaints in the low back and right lower extremity. An MRI scan from February 2007 describes minor disc protrusions at L4-5 and L5-S1 without a description to suggest significant neuro-foraminal compression. Of note, EMGs from February 2007 describe chronic right-sided L4 radicular complaints.

Subsequently, this gentleman underwent multiple epidural steroid injections but continues to complain of a combination of back and right lower extremity pain. It is noteworthy that a subsequent set of EMGs describe chronic right L4 and L5 radiculopathy. There is no evidence of acute denervation. Subsequently, this gentleman was seen by Dr. for a neurosurgical opinion. Dr. recommended two level decompression following his 07/11/07 note. He based this on the fact that the claimant had failed conservative treatment and that he had leg pain greater than back pain as well as a positive straight leg raise and weakness in his right extensor hallucis longus.

The Reviewer cannot recommend the proposed treatment as being reasonable or medically necessary. Imaging studies, in the Reviewer's opinion, do not fit with the findings on original EMGs and/or the subsequent set of EMGs. In spite of the fact that the EMGs from 06/26 suggest chronic L5 nerve irritation, a repeat MRI scan was not ordered which may clarify as to whether or not this gentleman has had interval change in the subsequent findings and/or if he in fact has distinct neural compression that may be

relieved with the decompression. Furthermore, this gentleman reportedly has weakness in both the left and right lower extremities which does not fit the radiographic findings and/or EMG reports. As such, based on these inconsistencies as well as the fact that this gentleman's original MRI scan does not reveal an obvious neurocompressive lesion, the Reviewer cannot recommend the proposed treatment as either being reasonable or medically necessary. In particular, the information available does not meet ODG guidelines as it pertains to concordance between the radiographs and the reported radicular findings.

**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)