IRO America Inc.

An Independent Review Organization
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DATE OF REVIEW:
JUNE 1, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Bilateral posterior decompression L2-3, L3-4, L4-5 and L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
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, xx/xx/xx
EMG, 07/12/05
Lumbar CT post myelography, 07/22/05
Neurosurgical consultation note, 08/18/05
Lumbar spine CT with and without contrast, 08/15/06
Office note, Dr., 09/21/06.
notification of determination 02/22/07 and 03/30/07
Texas Dept of Insurance notice to IRO, 05/21/07
Urgent Request for Medical Records, 05/24/07

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who reportedly sustained a lifting injury to his back on xx/xx/xx. The medical records indicated that the claimant had undergone

lumbar laminectomies in xxxx, 1986 and xxxx, and was status post posterior decompression and fusion at L5-S1 in 1996. The claimant complained of continued low back pain and leg pain. A CT of the lumbar spine on 06/08/2004 showed the presence of a spinal cord stimulator with electrodes terminating at the level of L4. There was evidence of laminectomy and posterior fusion at L5-S1, no evidence of recurrent disc, L4-5 stenosis, bulging disc, disc disease and spondylosis, and foraminal stenosis at L2-3, L3-4 and L5-S1.

An EMG of the bilateral lower extremities on 07/12/2005 found a chronic old resolved left L5-S1 radiculopathy with no acute changes, normal right studies, and no evidence of peripheral neuropathy. A lumbar X-ray on 07/22/2005 showed fusion masses from L4 to S1, moderate to severe decrease in disc space at L5-S1 and mild endplate spondylosis throughout the lumbar spine. Lumbar CT myelography on 07/22/2005 showed mild to moderate mass effect upon the ventral and dorsal aspect of the thecal sac at L4-5 and mild mass effect at L2-3 and L3-4. Solid fusion masses were present at L5-S1, moderate lateral recess narrowing and spinal stenosis was present at L4-5 with a 3 to 5 millimeter broad-based posterior disc protrusion, moderate to severe facet joint and ligamentum flavum hypertrophy, and moderate mass effect upon the L5 descending nerve root bilaterally. Moderate neural foraminal narrowing with possible mild mass effect upon the L4 exiting nerve root, mild narrowing of the lateral recess at L3-4 and L2-3 with mass effect upon the descending nerve roots and degenerative changes of the SI joints bilaterally was also present. The claimant continued to complain of back pain with spasm, posterior thigh and calf pain with radiation into the lateral foot, and back pain greater than leg pain. A neurosurgical examination on 08/18/2005 found normal gait, strength, reflexes and neurovascular status. A discogram was recommended but it is unknown if it was obtained.

On 08/15/2006 a CT of the lumbar spine was obtained, which showed no disc herniations in the lumbar spine, bilateral facet arthritic changes and mild narrowing of the neuro-foramina due to a bulging disc and facet arthrosis at L4-5, and laminectomy changes with neurostimulator in place at L5-S1. The claimant continued to complain of low back pain greater than leg pain. Dr. 09/21/2006 office note indicated that the claimant had treated conservatively with anti-inflammatories, muscle relaxants, pain medications, physical therapy and steroid injections without significant relief. Physical examination found 4/5 bilateral hamstring and quadriceps strength. A request for bilateral posterior decompression at L2-3, L3-4, L4-5 and L5-S1 was denied by the insurance carrier on 02/22/2007 and 03/30/2007.

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

The claimant is a gentleman who has had multiple operative procedures of the lumbar spine. He has undergone a 06/08/04 CT scan of the lumbar spine

documenting degenerative disc disease with some stenosis. A 07/12/05 EMG documented chronic resolved left L5-S1 radiculopathy with no acute changes. A 07/22/05 CT myelogram of the lumbar spine describing postsurgical changes and stenotic changes as well as an 08/15/06 CT myelogram of the lumbar spine, whose report describes degenerative changes. There is a single 09/21/06 office visit of Dr., neurosurgeon, that describes the fact that the claimant has had four prior lumbar surgeries, most recently a 1996 fusion and has some weakness of his hamstring and quadriceps strength bilaterally and surgical intervention is requested. There is no documentation in this medical record of progressive loss of function, significant ongoing neurologic deficit, specific failure of conservative care or exactly why the surgery is being requested. Therefore the requested bilateral posterior decompression of L2-L3, L3-L4, L4-L5 and L5-S1 is not medically necessary or reasonable since there is essentially no documentation in the medical record as to why this surgery is needed or being requested.

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

Recommended for indications below. Surgical discectomy for carefully selected patients with radiculopathy due to lumbar disc prolapse provides faster relief from the acute attack than conservative management, although any positive or negative effects on the lifetime natural history of the underlying disc disease are

still unclear. Unequivocal objective findings are required based on neurological examination and testing. (Gibson-Cochrane, 2000) (Malter, 1996) (Stevens, 1997) (Stevenson, 1995) (BlueCross BlueShield, 2002) (Buttermann, 2004) Standard discectomy and microdiscectomy are of similar efficacy in treatment of herniated disc. (Bigos, 1999) While there is evidence in favor of discectomy for prolonged symptoms of lumbar disc herniation, in patients with a shorter period of symptoms but no absolute indication for surgery, there are only modest short-term benefits, although discectomy seemed to be associated with a more rapid initial recovery, and discectomy was superior to conservative treatment when the herniation was at L4-L5. (Osterman, 2006) The SPORT studies concluded that both lumbar discectomy and nonoperative treatment resulted in substantial improvement after 2 years, but those who chose discectomy reported somewhat greater improvements than patients who elected nonoperative care. (Weinstein, 2006) (Weinstein2, 2006) A recent RCT compared decompressive surgery with nonoperative measures in the treatment of patients with lumbar spinal stenosis, and concluded that, although patients improved over the 2-year follow-up regardless of initial treatment, those undergoing decompressive surgery reported greater improvement regarding leg pain, back pain, and overall disability, but the relative benefit of initial surgical treatment diminished over time while still remaining somewhat favorable at 2 years. (Malmivaara, 2007) Patients undergoing lumbar discectomy are generally satisfied with the surgery, but only half are satisfied with preoperative patient information. (Ronnberg, 2007) [Note: Surgical decompression of a lumbar nerve root or roots may include the following procedures: discectomy or microdiscectomy (partial removal of the disc) and laminectomy, hemilaminectomy, laminotomy, or foraminotomy (providing access by partial or total removal of various parts of vertebral bone).]

- ☐ 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)