

P-IRO Inc.

An Independent Review Organization

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Final Amended April 6, 2007

Amended March 14, 2007

DATE OF REVIEW: March 12, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral re-do L3-4 and L4-5 Laminectomy discectomy open (63042, 63047, 69990, 76000)

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.

- Bilateral re-do L3-4 is NOT medically necessary
- L4-5 Laminectomy discectomy open IS medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office notes, Dr., 01/04/06, 02/02/06, 04/10/06, 07/10/06 and 11/10/06

Office notes, Dr., 01/17/06, 02/17/06, 03/17/06, 04/07/06, 05/19/06, 07/18/06,
08/15/06, 09/08/06, 09/19/06, 10/24/06 and 12/18/06
Lumbar spine MRI, 01/20/06 and 02/09/07
AP lateral views lumbar spine, 01/20/06 and 02/09/07
Office notes, Dr., 02/01/06, 02/10/06 and 07/26/06
Operative report, 03/23/06
Letter to Dr. from Dr., 05/12/06 and 07/07/06
Letter, Dr., 05/15/06
Lumbar MRI, 07/21/06
EMG, 07/27/06
Letter, Dr., 11/14/06
Letter from Dr. to Dr., 11/29/06
denial noted, 12/06/06 and 01/04/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a female who developed gradual onset of low back pain while at work. The claimant treated initially with chiropractic treatment. The lumbar MRI showed a 3.5 millimeter subligamentous disc protrusion with considerable canal and lateral recess stenosis bilaterally at L4-5. There was disc desiccation of the disc material at this level. There was slight to moderate canal stenosis associated with facet hypertrophy at L3-4. The claimant first saw Dr. for a six week history of back and right leg pain. Exam findings revealed weakness of the anterior tibialis muscle group, positive straight leg raise and symmetric reflexes. Tenderness was noted at the right paraspinal muscle region. Dr. reviewed the lumbar MRI and felt that it showed evidence of a herniated disc at L4-5 with right sided L5 root impingement. Based on exam findings and imaging, Dr. recommended surgical decompression.

The claimant continued to treat with Dr. of chiropractics and Dr. of pain management with rehabilitation and medications. After a failure to respond to conservative treatment, the claimant underwent a 03/23/06 right sided L4-5 minimally invasive laminectomy and discectomy by Dr.

The claimant reported to Dr. on 04/07/06 noted 20 to 30% improvement of her right leg pain and she was starting to have left leg pain. Exam findings were non focal. Dr. recommended rehabilitation as suggested by the surgeon. The claimant continued to see Dr. who documented on 04/10/06 that the return to work goal was 06/01/06. A follow up visit with Dr. on 05/12/06 documented a small knot under the incision area; right leg markedly improved and left leg pain. Dr. felt that the claimant was recovering from the laminectomy/discectomy and was having bilateral leg pain and back pain. Recommendation was to follow up in three months.

Dr. recommended a lumbar MRI on 05/19/06. Exam findings revealed 4/5 strength in bilateral lower extremities with tiptoes/heel/walking/squatting eliciting pain over the lumbar area. Dr. noted that the claimant's right leg pain was almost resolved on 07/07/06 but the left leg was progressively worsening. The claimant had failed physical therapy. The claimant reported weakness left leg and back

pain markedly improved. Exam findings revealed decreased sensation dorsum of left foot, mild weakness of the dorsiflexor muscle groups on left, and a mass under the incision that was consistent with keloid formation. Dr. felt that the initial MRI showed bilateral stenosis at L4-5 which was in addition to the right sided herniated disc. Dr. further added that all of the claimant's right sided symptoms responded extremely well to surgery and that the left sided symptoms may be a function of progressive stenosis. The lumbar x-rays that day showed no evidence of flexion and extension instability with previous laminectomy.

On 07/10/06, Dr. gave the claimant an 11% impairment rating for the lumbar spine. Dr. on 07/18/06 recommended electromyography and repeat lumbar MRI. The 07/21/06 lumbar MRI showed previous right sided laminectomy at L4-5, moderate severe compromise spinal canal at L4-5 due to congenitally small spinal canal and shallow disc protrusion. There was soft tissue material on right side of canal which showed homogeneous enhancement indicating no evidence of recurrent disc herniation in the right side of canal. There was moderate compromise of spinal canal at L3-4 due to congenitally small canal. There was no other compromise of the spinal canal or neural foramina by either disc material or hypertrophic bone at any other level.

On 07/26/06, Dr. saw the claimant for persistent back and left leg pain. Exam findings revealed essentially the same findings with a normal gait. Dr. reviewed the lumbar MRI and felt that it showed adequate decompression, previously herniated disc was resolved and a central disc herniation at L4-5. There was moderate to severe spinal stenosis due to congenital narrowing at this level and moderate stenosis at L3-4 segment again due to congenital canal narrowing. Dr. recommended injections, and therapy and if no improvement then completion of the laminectomy.

The 07/27/06 electromyography showed superimposed radiculopathy involving the left sided L5 and S1 nerve roots. Dr. recommended epidural steroid injections on 08/15/06 which were denied by the insurance carrier. On 09/19/06, Dr. noted some improvement with pain management and decided to hold requests for injection therapy. The claimant noted increased lumbar spine pain with radiation to the left lower extremity with some numbness, tingling and weakness all the way down the leg. Exam findings revealed a positive straight leg raise on the right at 45 degrees and the left was 35 degrees. Squatting, tiptoe, and heel walking elicited pain. Sensory revealed hyperalgesia to pinprick to light touch over the posterior lumbosacral area and left lower extremity in the L5-S1 dermatomal distribution.

Dr. felt the claimant had failed conservative management and recommended an open bilateral lumbar laminectomy based upon exam findings of weakness, sensory loss and positive straight leg raising bilaterally. Dr. felt that the lumbar MRI showed L3-4, L4-5 stenosis and nerve impingement and a disc protrusion. On 12/06/06, denied the request for L3-4 and L4-5 laminectomy discectomy stating that the redo/repeat surgery was necessitated by congenital stenosis with new onset symptoms and had no association to work. A review on 01/04/07 by Dr. recommended repeat MRI as previous 07/21/06 imaging did not explain left

sided symptomatology. The 02/09/07 lumbar MRI showed disc pathology with hypertrophic facet joints involving L3-4, L4-5 and L5-S1. There was considerable canal and lateral recess stenosis involving the L3-4, L4-5.

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

At issue is the request for bilateral re-do L3-4 and L4-5 laminectomy/discectomy. This claimant is of age. She underwent, in March of 2006, a right-sided L4-5 minimally invasive laminectomy and discectomy. However, she is now complaining of progressive pain down her left lower extremity. She has had two MRI's post-operatively and a nerve conduction study which shows superimposed radiculopathy involving the left side of L5 and S1 nerve roots. The most recent MRI demonstrates considerable canal and lateral recent stenosis of L3-4 and L4-5 noted. The claimant has both sensory and motor deficits noted in the documentation. She has failed conservative care thus far including injection therapy, medication, and physical therapy. In flexion/extension radiography, there appears to be no evidence of instability following the first laminectomy. It appears that it is reasonable and medically necessary to proceed with bilateral re-do laminectomy and discectomy at the L4-5 level based on the records provided. Bilateral surgery would be indicated as the claimant has bilateral stenosis with abnormal EMG findings in the left lower extremity and with scarring from the previous surgery on the right.

However, the records indicate that the physician is planning to perform surgery at the L3-4 level as well and the indications for surgery at this level are unclear based on review of the records alone. In addition, the claimant has had a repeat MRI since the previous utilization reviews and there are no updated office notes from Dr. discussing his surgical plan. Therefore, based on review of the records provided, the adverse determination is upheld for the L3-4 level.

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)