CompPartners

Notice of Independent Review Decision

DATE OF REVIEW: 11/27/07 AMENDED DATE: 12/12/07

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVIDES IN DISPUTE

Determine the medical appropriateness of the previously denied request for laminectomy/disc, L4-5, left.

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

Texas Licensed Board Certified Orthopedic Surgeon.

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)

The previously denied request for laminectomy/disc, L4-5, left.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- **Fax Cover Sheet dated 11/19/07.**
- **Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 11/16/07.**
- **Request for a Review by an Independent Review Organization dated 11/15/07.**
- **Determination Notification Letter dated 11/7/07, 10/26/07.**

- **Letter dated 11/19/70.**
- **Physician Record dated 8/13/07.**
- **Accident Report dated 5/14/07.**
- **Follow-Up Visit Note Report dated 7/23/07.**
- **Lumbar Spine MRI (with/without Contrast) dated 5/30/07, 5/10/05, 7/15/04, 12/20/03.**
- **Progress Note dated 1/6/04, 12/23/03, 12/17/03, 12/3/03.**
- **Lumbar Spine X-Ray dated 6/14/05.**

No Guidelines were provided by the URA for review

PATIENT CLINICAL HISTORY [SUMMARY]:
Age:
Gender: Male
Date of Injury:
Mechanism of Injury: Working with a hose with oil in it.

Diagnosis: Left Lumbar disc herniation at L4-5 and L5-S1

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

This claimant injured his low back when he was working with a hose that had oil in it. A lumbar MRI, on 12/20/03, demonstrated a left paracentral disc protrusion/herniation at L4-5 and L5-S1 with impingement/abutment on the left fourth and fifth lumbar nerve roots. The claimant underwent an L4-5 microdiscectomy on 5/17/04. A lumbar MRI on 7/15/04 showed post-operative changes about the left lateral recess and about the posterior elements at L4-5, consistent with scarring. A repeat MRI, on 5/10/05, showed enhancement along the left side of the thecal sac at L4-5 and, in particular, around the proximal aspect of the left L4 root, which could indicate scarring. Discography was performed on 6/14/05. L2-3 was normal. L3-4, L4-5 and L5-S1 were all abnormal with 10/10 pain. On the CT scan, there was a central and far right lateral disc protrusion with mass effect on the thecal sac at L4-5. The records indicated that the claimant was determined not to be a surgical candidate at that time, based on multilevel disease, and was referred for chronic pain management. A morphine pump was inserted on 4/11/06. A lumbar MRI was done on 5/30/07, which showed mild degenerative disc disease at L3-4 and mild-to-moderate degenerative disc disease at L4-5 and L5-S1. A left posterior lateral extruded disc at L4-5 was seen consistent with disc herniation in the left paracentral region. There was degenerative disc disease with annular tear of the posterior aspect of the L3-4 disc. Dr. evaluated the claimant on 7/23/07 for low back pain with left lower extremity pain. He indicated that the claimant had last been seen in August 2005 for the same problem. The pain was getting worse and radiated to the left lower extremity all the way into the foot and toes. There was a new onset of numbness in the groin, which Dr. indicated was the reason for the MRI in May 2007 being ordered. The claimant was receiving Dilaudid in his pain pump. He was taking Hydrocodone, Zanaflex, Lyrica, Lexapro and Celebrex. On exam he had an antalgic gait and was using a cane. He had tenderness in the mid thoracic and sacroiliac joints. The claimant had significant paraspinal guarding bilaterally. Left tibialis anterior strength was 4-/5 and extensor hallucis

longus strength was 2/5. Reflexes were 2+. Sitting straight leg raise resulted in back pain. A review of the MRI from 5/30/07 showed left paracentral disc herniation at L4-5 moderate size effacing the thecal sac, and at L3-4 a mild central disc bulge. The impression was severe chronic low back pain with radiculopathy and large left L4-5 paracentral disc herniation. He noted that the claimant had equal back and leg pain and recommended anterior lumbar discectomy and fusion at L4-5. Peer reviews were performed on 10/26/07 and 11/07/07, in which the surgical request was for laminectomy and discectomy at L4-5 and was denied based on lack of current clinical information. This case has been reviewed on two occasions, on 10/26/07 and on 11/07/07, the former by Dr. and the latter by Dr. both of which did not approve the procedure, a lumbar laminotomy and discectomy at L4-5. The last office notes reviewed were dated July 2007. Without additional records to determine the claimant's current clinical condition, it is not clear why the physician recommended an anterior lumbar interbody fusion at L4-5, but the current surgical request is for a laminectomy and discectomy at L4-5.

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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back: Discectomy/Laminectomy.
ODG Indications for Surgery -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA

Guides, 5th Edition, page 382-383. (Andersson, 2000) Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

B. L4 nerve root compression, requiring ONE of the following:

1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
3. Unilateral hip/thigh/knee/medial pain

C. L5 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
2. Mild-to-moderate foot/toe/dorsiflexor weakness
3. Unilateral hip/lateral thigh/knee pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

A. Nerve root compression (L3, L4, L5, or S1)
B. Lateral disc rupture
C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

1. MR imaging
2. CT scanning
3. Myelography
4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following:

A. Activity modification (not bed rest) after patient education (>= 2 months)
B. Drug therapy, requiring at least ONE of the following:

1. NSAID drug therapy
2. Other analgesic therapy
3. Muscle relaxants
4. Epidural Steroid Injection (ESI)

C. Support provider referral, requiring at least ONE of the following (in order of priority):

1. Physical therapy (teach home exercise/stretching)
2. Manual therapy (massage therapist or chiropractor)
3. Psychological screening that could affect surgical outcome
4. Back school (Fisher, 2004)

□ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

□ TEXAS GUIDELINES FOR CHRIOPRACTIC QUALITY ASSURANCE AND 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).

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.