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Notice of Independent Review Decision

DATE OF REVIEW: December 22, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Posterior lumbar laminectomy L4-5 right to include CPT Code 63056.

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

Diplomate, American Board of 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008

- , 02/14/08, 02/18/08, 02/20/08
- Work Status Report, 02/14/08, 02/18/08, 02/21/08, 02/26/08, 03/10/08, 03/20/08, 03/24/08, 04/05/08, 04/17/08, 05/09/08, 05/12/08, 05/09/08, 06/19/08, 07/01/08, 08/19/08, 09/26/08
- , 02/21/08, 03/06/08, 03/12/08, 03/17/08, 03/19/08, 03/20/08, 03/25/08, 03/27/08, 03/31/08, 04/03/08, 04/07/08, 04/10/08, 04/15/08, 04/17/08, 04/18/08, 04/21/08, 06/19/08, 08/19/08, 10/16/08, 12/18/08
- , 02/26/08, 03/06/08, 05/09/08, 06/03/08, 06/17/08, 07/01/08, 09/26/08, 10/24/08
- , 03/03/08
- , M.D., 03/10/08
- , P.A., 03/10/08
- , M.D., P.A., 03/24/08, 04/08/08, 04/29/08, 05/19/08, 06/24/08, 09/18/08,
- , 03/31/08
- , 04/23/08
- , 04/25/08
- , 04/30/08
- , 05/19/08
- , M.D., 07/28/08
- , 07/28/08
- ., 08/04/08, 08/13/08
- , 08/15/08
- , D.O., 09/08/08
- , 09/18/08
- , 10/06/08, 11/06/08
- , 10/06/08, 11/06/08
- Surgery Preauthorization Form, 10/30/08

Medical records from the Provider include:

- , 02/21/08, 03/06/08, 03/20/08, 04/03/08, 04/17/08, 06/19/08, 08/19/08, 10/16/08
- , 02/26/08, 03/06/08, 05/09/08, 06/03/08, 06/17/08, 07/01/08, 09/26/08, 10/24/08
- , 03/03/08
- , M.D., P.A., 03/24/08, 04/08/08, 04/29/08, 05/19/08, 02/14/08, 09/18/08,
- , 03/31/08, 09/18/08
- , 04/30/08
- , 10/06/08, 11/06/08
- DWC-69, Report of Medical Evaluation, 11/20/08
- , M.D., 11/20/08

PATIENT CLINICAL HISTORY:

The patient is a xx-year-old male who injured his back at work on xx/xx/xx. The physical findings on this patient have been decreased sensation to light touch along the left greater trochanter region and the lateral hip region; it does not indicate which side. The physical examination revealed a positive straight leg raise on the left at 40 degrees and on the right at 75 degrees. There was decreased sensation to light touch along the lateral greater trochanter region and lateral hip region on the left. The patient had a 5-/5 left anterior tibialis weakness and absent left Achilles tendon jerk. There was no atrophy.

The discogram revealed concordant low back, right groin, and buttock pain. However, this patient's pain has always been on the left side, and thus, response at the L4-5 level is not concordant as stated by the surgeon. The L5-S1 level was normal with no pain.

The CT scan revealed a grade II annular degeneration with grade I annular tear toward the right at the L3-4 level. At L4-5, the CT scan revealed no significant annular degeneration or tear. The L5-S1 level did not have pain with injection of the dye.

The MRI revealed only a 1-2 mm generalized L4-5 disc bulge. There was left high-signal intensity in the foraminal portion of the disc, which was compatible with an annular fissure.

However, on discography a tear was not found at the L4-5 level. There were no herniations or foraminal stenosis. The L5-S1 disc space revealed no disc herniation or bulging. A note should be made of the fact that the finding at the L4-5 level is on the left, and the operation that is being requested is on the right of the L4-5 level. The L3-4 disc space revealed a 2 mm generalized disc bulge without herniation or stenosis. The other levels were unremarkable, as well.

On the CT scan, there was an L2-3 left-sided facet hypertrophy. There was not significant facet hypertrophy noted at other levels. The MRI did not reveal facet hypertrophy at other levels, as well.

The current diagnosis includes lumbar radiculopathy with positive discogram, low back pain, and L4-5 annular tear. The treatment has included medication and therapy, as well as epidural steroid injections which were not beneficial.

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

The requested procedure is a posterior lumbar laminectomy at L4-5 on the right. The requested procedure is not medically necessary or reasonable because the patient does not have any objective signs of true radiculopathy, such as loss of relevant reflexes (the patient has been documented only once with an absent left Achilles tendon jerk, which relates to an L5-S1 level, and the L5-S1 level is completely devoid of pathology, both by the discogram and by MRI/CT scanning). The patient has a positive straight leg raise on the left at 40 degrees, however, the procedure being requested is on the right. Also, the reported absent Achilles tendon jerk is on the left. This also is on the wrong side of the requested procedure and it involves the L5-S1 level which is devoid of any pathology per imaging studies and other examinations by other providers. Also, the discogram was reported to be concordant at L4-5. However, on review of the operative report, the patient had low back pain and right-sided pain and right hip pain. The patient has consistently complained of left-sided pain. Therefore, the discogram is not concordant. The discogram/CT scan did not reveal annular tears in the L4-5 level.

Additionally, evidence-based guidelines, such as ODG Guidelines, necessitate documentation of at least one significant finding (unilateral weakness/atrophy or unilateral pain in the corresponding nerve root distribution), at least one imaging study (MRI, CT myelography, or CT myelography and x-ray) finding nerve root compression, lateral disc rupture, or lateral recess stenosis, failure of conservative treatment (activity modification plus at least one: NSAIDs, other analgesic therapy, muscle relaxants, or epidural steroid injection), and at least one supporting provider referral (physical therapy, manual therapy, psychological screening, or BECK score) to support the medical necessity of lumbar decompression.

Based on a review of the available medical records, therefore, certification of the requested posterior lumbar laminectomy at L4-5 on the right is not recommended. As stated above, the wrong side is being addressed and imaging studies do not confirm or support the procedure being requested. Additionally, the physical findings as noted above do not support the procedure being requested.

Furthermore, the ODG indication for decompression at L5 include: At least one symptom/finding, such as unilateral foot/toe/dorsiflexor weakness/atrophy or unilateral hip/lateral thigh/knee pain. At least one imaging, such as MRI, CT myelography, or CT myelography and x-ray finding of an L5 nerve compression, lateral disc rupture, or lateral recess stenosis), failure of conservative treatment (activity modification plus at least one: NSAIDs, other analgesic therapy, muscle relaxants or epidural steroid injection), At least one supporting provider referral (physical therapy, manual therapy, psychological screening or BECK score).

In addition, ACOEM Guidelines support lumbar surgical consultation/intervention for patients who have severe and disabling lower leg pains in the distribution consistent with abnormalities on imaging studies, which this patient does not have. This should be

preferably accompanied by objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; clear clinical imaging and electrophysiologic evidence of a lesion that has been shown to benefit, both short- and long-term, from surgical repair; failure of conservative treatment to response disabling radicular symptoms (ACOEM, Chapter 12, pages 305-306).

In conclusion, based on the lack of objective physical findings that support a true radiculopathy, based on the non-concordant discogram as reviewed by this examiner, based on the request for the wrong side of the patient's consistent complaints, and based upon the peer-reviewed guidelines documented above, the request for a posterior lumbar laminectomy is not certified.

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)**