

SENT VIA EMAIL OR FAX ON  
Dec/29/2008

## Applied Resolutions LLC

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/29/2008

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Inpt. Bil Hemilaminectomy Medial Facectomy Foraminotomy @L5/S1 LOS 1 day

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

**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**

OD Guidelines

Denial Letters 11/24/08 and 12/4/08

Medical Record from Dr. 11/14/08

Records from Dr. 01/14/2008, 01/29/2008, 02/21/2008, 03/26/2008, 05/12/2008, 07/10/2008, 09/09/2008, 10/14/2008

Records from 5/7/08 and 8/27/08

Myelogram/post-myelo CT report 8/1/08

CT of the Lumbar spine report 1/25/08

Operative report reports 11/21/1994, 10/27/2007, 11/14/07  
10/27/07 thru 11/13/08

Post Myelogram Lumbar CT 7/6/07

Record from Dr. 7/18/08

Record from Dr. 6/23/08

CT Scan Lumbar 9/23/98

Lumbar myelogram, post-myelo CT, and discogram 10/15/94

**PATIENT CLINICAL HISTORY SUMMARY**

This is a xx year-old male with a date of injury xx/xx/xx, when he was reaching to get something out of his truck. He is status post L3-L5 fusion in 1994 and on 10/27/2007

underwent a bilateral decompression at L2-L3. He developed a CSF leak and on 11/14/2007, he underwent repair of the leak with laminectomy at L4. He complains of progressively worsening back pain with radiation into the buttocks and down the posterior aspect of bilateral lower extremities. He has had NSAIDs, pain medications, muscle relaxants, PT, and ESI's. His neurological examination reveals some weakness in quadriceps and hamstrings. An EMG/NCV 06/23/2008 showed a polyradiculopathy. A CT myelogram of the lumbar spine 08/01/2008 reveals a large 1.6 cm transverse and 6.0mm AP and 2.6 cm cranial-caudal epidural mass extending along the posterior L2 vertebral body to mid-vertebral body causing moderate to severe constriction of the thecal sac. This is consistent with a reherniated disc at this level. At L5-S1 there is no disc herniation or spinal stenosis. The provider is recommending bilateral hemilaminectomy, medial facetectomy and foraminotomy at L5-S1.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The bilateral hemilaminectomy, medial facetectomy, and foraminotomy, at L5-S1 is not medically necessary. There is no pathology indicated at L5-S1 on the CT myelogram. The claimant does not have symptoms referable to the L5-S1 level. Clearly, surgery is warranted at L2-L3, but this request is for decompressive surgery at L5-S1, which is not warranted, based on the clinical information provided. According to the ODG, there should be objective findings on examination that correlate with radiographic findings, in order for surgery to be warranted. These are not present in this case.

#### References/Guidelines

##### ODG "Low Back" chapter

Indications for Surgery -- Discectomy/laminectomy -- Rationale :- 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: A. L3 nerve root compression, requiring ONE of the following: 1. Severe unilateral quadriceps weakness/mild atrophy 2. Mild-to-moderate unilateral quadriceps weakness 3. Unilateral hip/thigh/knee pain 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 D. S1 nerve root compression, requiring ONE of the following: 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness 3. Unilateral buttock/posterior thigh/calf 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)

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

- ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)