



Medical Review Institute of America, Inc.  
America's External Review Network

DATE OF REVIEW: February 25, 2008

IRO Case #:

**Description of the services in dispute:**

CPT code #63047 for a Lumbar Laminectomy at L5-S1 denied for lack of medical necessity.

**A description of the qualifications for each physician or other health care provider who reviewed the decision**

The physician who provided this review is a fellow of the American Board of Orthopaedic Surgery. This reviewer is a fellow of the North American Spine Society and the American Academy of Orthopaedic Surgeons. This reviewer has been in active practice since 1990.

**Review Outcome**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld. The proposed lumbar laminectomy at L5-S1 is not medically necessary.

**Information provided to the IRO for review**

RECORDS RECEIVED FROM THE STATE:

Confirmation of Receipt of IRO, dated 2/6/08, 7 pages

Report dated 12/28/07, 1/23/08, 14 pages

RECORDS RECEIVED FROM DR.:

MRI of the lumbar spine dated 02/22/07, 2 pages

Progress notes from Orthopedic Center, 4/12/07, 1 page

Report dated 4/23/07, 7/10/07, 6/23/07, 11/6/07, 12/28/07, 6 pages

Texas Workers Compensation work status report, dated 4/26/07, 4/12/07, 2 pages

Work Comp Verification for Diagnostic/Surgical Procedures, 7/5/07, 8/9/07, 2 pages

**RECORDS:**

Carrier notes from Management, Inc., 5 pages

Employer's first report of injury or illness, 3 pages

Progress notes, Dr. M.D., 1/5/07, 2 pages

Work status reports, 1/5/07, 1/12/07, 1/26/07, 2/9/07, 2/16/07, 3/2/07, 4/3/07, 5/23/07, 5/28/07, 7/27/07, 8/20/07, 8/29/07, 9/20/07, 10/24/07, 11/14/07, 12/19/07, 1/10/08, 17 pages

History and physical exam from Orthopedic Group dated 01/12/07, Dr. M.D., 1 page

Physical therapy progress notes from Physical Therapy, 16 pages

Progress notes Orthopedic Group, 1/26/07, 2/9/07, 2/16/07, 3/2/07, 4/3/07, 5 pages

MRI of the lumbar spine dated 02/22/07, 2 pages

MRI of the left hip dated 02/22/07, 1 page

Operative report Orthopedic Surgery Center, caudal epidural steroid injection at the L5-S1 level dated 05/08/07, 2 pages

Progress notes from Orthopedic Center, 38 pages

Operative report Orthopedic Center, epidural steroid injection at L5-S1 dated 07/17/07

Lumbar myelogram dated 11/30/07, 2 pages

CT scan of the lumbar spine with contrast post myelogram dated 11/30/07

Letter dated 6/29/07 from Orthopaedic, 2 pages

Letter dated 9/10/07 from Orthopaedic, 1 page

**Patient clinical history [summary]**

The patient is a female who was driving a forklift. She stated she shifted in her seat with her left buttocks up when her left buttocks hit a metal post and was pinched. She reported pain that was instantaneous and severe. The patient reported her injury to her employer. In her worker's compensation request for medical care, her physician described bruising of the upper left thigh, prescribed modified duty and diagnosed the patient with a left hip contusion. She was also given a prescription for Ibuprofen. She was seen at the Orthopedic Group on 01/12/07 by Dr. M.D. who reviewed x-rays which he reports clinically as showing no fractures or osseous abnormalities. His physical exam states the left hip has a small hematoma. There was tenderness, swelling and a contusion. He states the patient had good range of motion and a normal gait. He also noted that the patient had decreased subjective sensation in the great toe. His assessment was a left hip contusion, hematoma and possible sciatic nerve neuropraxia. His prescription was rest, ice and work modification and to follow up in clinic in 2-3 weeks for clinical reevaluation. The patient also went to Physical Therapy on 01/12/07. On 02/09/07 the patient returned to Orthopedic Group for reassessment. In the history section of that progress note the patient stated that her symptoms had

resolved. She was having no difficulties and she felt ready to return to work. Physical exam stated that the lower extremity was neurovascularly intact. The skin was intact. Compartments were soft. Sensation was normal. There was no swelling or tenderness. The patient had a normal gait. Assessment was status post neuropraxia and hip contusion. Plan was to return to work without restriction and to follow up as needed. There is a progress note from Orthopedic Group dated 02/16/07 in which the patient stated she was having difficulty with her hip since returning to work and an MRI was ordered. An MRI of the lumbar spine was done on 02/22/07 at the Medical Center and read by Dr. M.D. This showed desiccated disc at L5-S1 with mild and diffuse bulging disc involving the anterior epidural space only. No spinal canal stenosis or narrowing of the neural foramen was noted. Mild disc space narrowing at L1-2 and at the thoracolumbar junction but no associated disc bulge or focal disc herniation was noted. In the findings section, it is noted that at L5-S1, no compression of the thecal sac or narrowing of the neural foramen was seen. Additionally, an MRI of the left hip was done showing no significant abnormalities. The patient continued with physical therapy. The patient underwent two different epidural steroid injections, one in May 2007 and the other in July 2007. Both were at the L5-S1 level. The patient reported that these did not provide much relief, however. She continued to complain of left lateral hip pain. The patient underwent lumbar myelogram on 11/30/07 and the impression stated it was an unremarkable lumbar myelogram. There was no evidence of spinal canal stenosis or disc herniations demonstrated. CT scan of the lumbar spine post myelogram was normal. There was no definite evidence of focal disc herniation or spinal canal or foraminal stenosis. The patient was seen in follow up at Orthopedic Center on 12/19/07. The patient's physician, Dr. M.D., stated that he reviewed the myelogram and post myelogram CT with Dr. a neurosurgeon. It was Dr. 's impression that the patient had a herniated nucleus pulposus at L5-S1 on the left with some central protrusion as well. His recommendation was to proceed with a lumbar laminotomy at L5-S1 on the left. This was requested through the insurance carrier on 12/21/07 with an adverse determination made on 12/28/07 by Dr. This decision was appealed and received another adverse determination on 01/23/08 from Dr.

**Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.**

The proposed lumbar laminectomy at L5-S1 is not medically necessary. The MRI from 2/22/2007 does not report significant pathology. The subsequent lumbar myelogram was unremarkable with no evidence of extradural compressions and no focal disc herniations. There was no evidence of central or lateral canal stenosis. The interpretation of the CT scan of the lumbar spine post myelogram dated 11/30/07 was initially read by M.D. as a normal CT scan of the lumbar spine with no definite evidence of focal disc herniations or spinal canal or foraminal stenosis. There is a second imaging report for this same CT scan from the Orthopedic Center made by Dr. who is a neurosurgeon. These interpretations contradict one another. Additionally, there is no preoperative

psychological assessment. In conclusion, the laminectomy of the lumbar spine at L5-S1 is not medically necessary.

**A description and the source of the screening criteria or other clinical basis used to make the decision:**

The Official Disability Guidelines