



# PROFESSIONAL ASSOCIATES

## Notice of Independent Review Decision

### IRO REVIEWER REPORT – WC (Non-Network)

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**DATE OF REVIEW:** 01/08/08

**IRO CASE #:**

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

Posterior Decompression, Laminectomy at L2-L3, L3-L4, and L4-L5

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

Board Certified 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)

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.

Posterior Decompression, Laminectomy at L2-L3, L3-L4, and L4-L5 - Upheld

#### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

A procedure note from M.D. dated 10/16/06

Evaluations with Dr. dated 10/23/06, 11/20/06, 12/18/06, 01/29/07, 03/12/07, 03/26/07, 04/23/07, 05/21/07, 06/25/07, 08/06/07, 09/17/07, 10/22/07, and 11/19/07

An MRI of the lumbar spine interpreted by M.D. dated 01/22/07

An evaluation and EMG/NCV study with M.D. dated 03/01/07

A letter of non-certification, according to the ODG Guidelines, from M.D. dated 05/14/07

A Designated Doctor Evaluation with M.D. dated 08/28/07

Letters of non-certification, according to the ODG Guidelines, from M.D. dated 12/05/07 and 12/11/07

A letter of non-certification, according to the ODG Guidelines, from M.D. dated 12/14/07

The ODG Guidelines were not provided by the carrier or the URA

### **PATIENT CLINICAL HISTORY**

On 10/16/06, Dr. performed an epidural steroid injection (ESI). On 10/23/06, Dr. recommended a myelogram CT scan. On 12/18/06, Dr. recommended an MRI of the lumbar spine. The MRI of the lumbar spine interpreted by Dr. on 01/22/07 revealed disc protrusions at L2 through L5 with stenosis. On 03/01/07, an EMG/NCV study with Dr. revealed evidence of possible central spinal canal lumbar stenosis at S1 only. On 03/12/07, Dr. recommended lumbar spine surgery. On 05/14/07, Dr. wrote a letter of non-certification for surgery. On 06/25/07, Dr. recommended a second surgical opinion. On 08/28/07, Dr. felt the claimant was not at Maximum Medical Improvement (MMI) and recommended either surgery or work hardening. On 09/17/07, Dr. continued to recommend surgery. On 12/05/07 and 12/11/07, Dr. wrote letters of non-certification for surgery. On 12/14/07, Dr. also wrote a letter of non-certification for the surgery.

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

The claimant appeared to have an L5 radiculopathy. The claimant had an EMG, which showed nerve root compression at the L5 nerve root only. The claimant had significant degenerative disease, consistent with his age and obesity. The decision to proceed with a multilevel decompression is more surgery that is warranted and would not improve the claimant's clinical condition. The claimant has not been treated with nerve root injections and has not maximized the physical therapy.

The ODG criteria for spinal decompression for L5 nerve root compression include weakness in appropriate distribution and numbness in appropriate decompression. The EMG obtained has not demonstrated the claimant has pathology at the upper lumbar levels.

In my opinion as a board certified orthopedic surgeon, with a specialty in spinal diseases, a posterior decompression and laminectomy at L2-L3, L3-L4, and L4-L5 is not

reasonable, nor necessary as related to the original injury. This is more surgery than is indicated by the clinical situation and is not calculated to yield a good clinical result.

**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 AND KNOWLEDGE BASE
- 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)