

# Applied Assessments LLC

*An Independent Review Organization*  
1124 N. Fielder Road, #179, Arlington, TX 76012  
(512) 772-1863 (phone)  
(512) 857-1245 (fax)

## Notice of Independent Review Decision

**DATE OF REVIEW:** 03/12/2008

**IRO CASE #:**

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

Inpatient lumbar laminectomy/decompression L4/L5 bilateral diskectomy with 2 day LOS.

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

Board Certified Nuerosurgeon 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)

Upon independent review the reviewer finds that the requested surgery of inpatient lumbar laminectomy/decompression L4/L5 bilateral diskectomy with 2 day LOS is not medically necessary.

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

Letters of denial to Dr. 01/30/2008, 02/20/2008  
ODG Guidelines and Treatment Guidelines  
Letter from Dr. to Dr. 01/24/2008  
Clinic note Dr. 09/26/2007  
CT myelogram report 11/20/2007

Procedure note lumbar myelogram 11/20/2007  
MRI of the lumbar spine report 06/25/2007  
Clinic notes Dr. 08/13/2007, 07/12/2007  
Plain films of the pelvis 07/12/2007  
Plain films of the hip 07/12/2007  
Plain films of the lumbar spine with flexion and extension 07/13/2007  
Electrophysiology report 07/12/2007

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a xx year-old male with a date of injury of xx/xx/xx when he fell from a trunk cab. The patient complains of low back pain with bilateral leg pain that was worse on the left, and numbness of the anterior thigh on the left. He has had medrol in the past. He has not had any documented physical therapy. A myelogram 11/20/2007 showed an extra-dural filling defect at L4-L5 which impinged on the descending L5 nerve roots bilaterally. The post-myelo CT scan revealed at L3-L4 bilateral neuroforaminal stenosis; at L4-L5 there was a large disc bulge with bilateral facet hypertrophy. There was mild impingement on the bilateral L5 nerve roots. At L5-S1 was a disc bulge with facet hypertrophy causing bilateral neuroforaminal narrowing. Neurological examination reveals decreased sensation to the lateral toes and left lateral calf from prior knee surgery. There is weakness in the left lower extremity. An MRI of the lumbar spine 06/25/2007 revealed L4-L5 disc bulge. At L5-S1 there is a disc bulge with an annular tear without central or foraminal stenosis. An EMG 07/12/2007 revealed a mild left L5/S1 radiculopathy.

The provider is requesting a laminectomy/decompression at L4-L5 with bilateral discectomy and a 2 day length of stay.

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

The surgery is not medically necessary for a number of reasons. Firstly, there is no documentation of physical therapy. The provider has recommended this to the patient, but there is no documentation that this was ever done. Secondly, while there may be some evidence of an L5 radiculopathy (it is not clear whether it is S1, L5, or both, from the report) on the left by EMG, there are no findings on examination to suggest an L5 radiculopathy. Moreover, there are no findings on the right to support a bilateral procedure.

According to ODG, discectom/laminectomy is indicated:

Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present.

Findings require ONE of the following:

- 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.)

Also,

Conservative Treatments, requiring ALL of the following:

- A. [Activity modification](#) (not bed rest) after [patient education](#) ( $\geq$  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](#)

Lastly, a 2-day length of stay is typically not medically necessary for a single-level lumbar decompression.

## **References/Guidelines**

2008 *Official Disability Guidelines*, 13th edition

Milliman Care Guidelines, 11<sup>th</sup> Edition, Inpatient and Surgical Care

**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)