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Notice of Independent Review Decision

DATE OF REVIEW: 05-22-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Laminectomy / Discectomy Redo L5

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

Certified by The American Board of Orthopaedic 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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	722.1 724.4 722.83	63407 63408	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letter dated 04-03-08 and 04-25-08
Physician Determination dated 03-28-08 and 04-17-08
Progress notes dated 05-11-04, 05-24-04, 06-10-04, 07-04-04, 09-07-04, 09-21-04, 10-11-04, 10-28-04, 11-30-04, 12-27-04, 02-08-05, 02-21-05, 03-08-05, 04-04-05, 04-26-05, 05-05-05, 05-19-05, 06-20-05, 07-21-05, 08-23-05, 05-19-05, 06-20-05, 02-07-06, 03-27-06, 07-18-06, 10-23-06, 02-26-07, 03-06-07, 06-21-07, 05-22-07, 07-16-07, 08-23-07, 01-14-08, 02-04-08, 03-25-08, and 04-08-08
Operative report dated 09-22-04, 09-04-07, 01-30-08
Surgical Pathology report reported 09-23-04
Designated Medical Doctor Evaluation dated 03-15-05
MRI lumbar spine dated 05-17-04, 06-08-05, and 06-12-07
Lumbar epidural steroid injection (ESI)
Pre-authorization requests/faxes
Official Disability Guidelines (ODG): Low Back "Discectomy/laminectomy"

PATIENT CLINICAL HISTORY:

The claimant underwent a surgical laminectomy and discectomy on September 22, 2004, performed by the requesting provider. A lumbar MRI dated June 12, 2007, noted the previous surgery, epidural scarring, osteochondrosis and osteosclerosis, and expected post-operative changes. Progress notes of January 14, 2008, noted that the claimant is doing better, has a reasonable range of motion, and suggested lumbar ESI. It was reported that the claimant was having some difficulty with ambulation. The claimant was declared totally disabled.

In March 2008, it was noted that the claimant was having "excruciating pain" into both lower extremities. The treating provider made an assessment of a recurrent L5 disc. The request for surgery was non-certified as not medically necessary.

On April 8, 2008, follow-up visit, it was noted that there was low back pain and difficulty in walking.

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

According to the Reviewer, it is noted in the Division mandated ODG (Updated May 6, 2008) "such a procedure is recommended for lumbar spinal stenosis. Discectomy should be reserved for those conditions of disc herniation causing radiculopathy. Laminectomy may be used for spinal stenosis secondary to degenerative processes exhibiting ligamental hypertrophy, facet hypertrophy, and disc protrusion, in addition to anatomical derangements of the spinal column such as tumor, trauma, etc." "Patients should be encouraged to return to their pre-injury activities as soon as possible with no restrictions at 6 weeks. Overall, patients with sequestered lumbar disc herniations fared better than those with extruded herniations, although both groups consistently had better outcomes than patients with contained herniations. Patients with herniations at the L5-S1 level had significantly better outcomes that did those at the L4-L5 level. Lumbar disc herniation level and type should be considered in preoperative outcomes counseling. Smokers had a significantly lower return to work rate. In the carefully screened patient, lumbar microdiscectomy for symptomatic disc herniation results in an overall high success rate, patient satisfaction, and return to physically demanding activities."

The Reviewer noted that the preoperative evaluation of the treating provider fails to support the diagnosis made or meet the criteria outlined in the ODG to justify the procedure. Based on the records submitted, there was no physical examination reported noting DTR's, any aspect of verifiable radiculopathy, and a repeat electrodiagnostic assessment of imaging studies less than 10 months old. In the opinion of the Reviewer and based on medical documentation, there is no clear, objective, independently confirmable medical evidence to substantiate the medical necessity of the procedure requested.

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)**