

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Fax: 214-594-8608

Notice of Independent Review Decision

DATE OF REVIEW: May 19, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facet.

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

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)

PATIENT CLINICAL HISTORY (SUMMARY):

This is a XX year-old male who was injured while working as a on XX/XX/XX. An MRI done in March of 2004 documented degenerative disc disease at L5-S1 as well as a focal central dorsal disc protrusion. Dr. performed surgery on April 15, 2004 inclusive of hemilaminotomy, foraminotomy, and discectomy right L5-S1. Postoperatively he underwent physical therapy and work hardening. In January of 2005 he was evaluated again with an MRI which documented a small to moderate recurrent central and minimally left sided disc herniation without extrusion. Dr. then proceeded with surgical intervention including an L5 laminectomy, L5 and S1 foraminotomies, a right L5-S1 discectomy, PLIF with a transforaminal approach at L5-S1 using cages and autogenous bone graft, and posterolateral fusion at L5-S1 with bone grafting and segmental spinal fixation.

The claimant returned to work status post the 2005 fusion procedure. He was again evaluated by Dr. in 2007 with notation in the office note of September 2007 indicating

that the MRI showed the surgical site to be well decompressed and that there was not any surgical pathology. Dr. next evaluated him in February and then March of 2008 with the claimant reporting pain in the leg and give-way sensation on the right with some numbness and tingling. X-rays continued to show solidity of the fusion with minimal degenerative changes at the level above the fusion. Exam was noted to show a mild root tension sign and no motor deficits. In February, he was to continue working, take Ultram and Mobic and then return for evaluation. The March office visit documented persistent complaints and Dr. at that time recommended additional surgery inclusive of a hemilaminotomy and foraminotomy on the right at L4-5 and L5-S1, removal of the spinal instrumentation at L5-S1, and bone grafting of the screw holes as the defects would be quite large noting that the posterolateral fusion could fracture in the screw defects.

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

This gentleman has previously undergone laminectomy and discectomy in April of 2004, following which he underwent laminectomy, decompression, and fusion in January of 2005. Subsequent to his surgery, he has continued to complain of back and right lower extremity pain. Records document that right leg symptoms have been present for more than two and one-half years.

Although imaging studies clearly document some degree of neural foraminal stenosis based on MRI scan from 09/07/07, it is unclear as to the indications for surgical decompression at this point in time. In particular, based on what appear to be persistent pain complaints following the original surgery, it does not appear as though efforts to determine if hardware was the source of his pain by either selective nerve root blocks and/or hardware injections have been completed. Obviously, a positive response in these particular settings may make a more compelling case for surgery.

In light of the fact, however, that this gentleman has had two previous surgeries and continues to have ongoing pain complaints that appear to be largely no different in the last several years, and that there does not appear to be signs of demonstrable instability, progressive neurologic deficit, and a conclusive workup to determine the source of his pain, the surgical request for hardware removal, repeat decompression, and bone grafting of the hardware sites would not be considered reasonable and medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Low Back: Laminectomy/laminotomy.

Recommended for lumbar spinal stenosis. For patients with lumbar spinal stenosis, surgery (standard posterior decompressive laminectomy alone, without discectomy) offered a significant advantage over nonsurgical treatment in terms of pain relief and functional improvement that was maintained at 2 years of follow-up, according to a new SPORT study. Discectomy should be reserved for those conditions of disc herniation causing radiculopathy. Laminectomy may be used for spinal stenosis secondary to degenerative processes exhibiting ligamentary hypertrophy, facet hypertrophy, and disc protrusion, in addition to anatomical derangements of the spinal column such as tumor, trauma, etc. (Weinstein, 2008) (Katz, 2008) Laminectomy is a surgical procedure for treating spinal stenosis by relieving pressure on the spinal cord. The lamina of the vertebra is removed or trimmed to widen the spinal canal and create more space for the spinal nerves. See also Discectomy/laminectomy for surgical indications, with the

exception of confirming the presence of radiculopathy.

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)