

PRIME 400 LLC
240 Commercial Street, Suite D
Nevada City, California 95959

Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 8, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lt Lami L3-5 w/foram, discect, medial facetectomy, decompression of L5 nerve root OP

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

Board Certified Neurosurgeon 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)

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.

The reviewer finds that medical necessity does not exist for Lt Lami L3-5 w/foram, discect, medial facetectomy, decompression of L5 nerve root OP.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 7/18/08, 8/8/08
ODG Guidelines and Treatment Guidelines
Dr., MD, 6/24/08, 7/15/08
Dr. , DO, 2/25/08, 1/24/08, 5/5/08, 3/28/08
MRI of Lumbar Spine report, 2/21/08
Plain films of the lumbar spine report 01/24/2008

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx year-old male has a date of injury xx/xx/xx while moving furniture. He complains of pain radiating down the hip, left groin area, and down the back of the left leg. He has had PT, medications, and ESI's. An EMG showed a left L4-L5 radiculopathy. His neurological examination reveals weakness in the left toes and foot and decreased sensation over the top of the left foot. MRI of the lumbar spine 02/21/2008 shows a 2mm disc bulge at L3-L4 with bilateral facet hypertrophy contributing to mild bilateral subarticular recess stenosis. There is no significant central or foraminal stenosis or nerve root impingement at this level. At L4-L5 there is a 6mm disc protrusion; there is mild central stenosis and bilateral recess stenosis. The provider is recommending a left laminectomy at L3-L5, discectomy, and medial facetectomy with decompression of the L5 nerve root

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

The surgery, as a whole, is not medically necessary based on the submitted documentation. As the other reviewers have pointed out, there does appear to be a medically necessary reason to decompress L4-L5 on the left, but not L3-L4. The imaging studies do not show a compressive lesion at that level. According to the Occupational and Disability Guidelines, "Low Back" chapter, there needs to be concordance between imaging findings and radicular findings on examination. Again, given the paucity of findings at L3-L4, the surgery, as a whole, is not medically necessary. The reviewer finds that medical necessity does not exist for Lt Lami L3-5 w/foram, discect, medial facetectomy, decompression of L5 nerve root OP.

References/Guidelines

2008 *Official Disability Guidelines*, 13th edition:
"Low Back" chapter:

ODG

ODG Indications for Surgery™ -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. ([Andersson, 2000](#)) Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

- A. L3 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral quadriceps weakness/mild atrophy
 - 2. Mild-to-moderate unilateral quadriceps weakness
 - 3. Unilateral hip/thigh/knee pain
- B. L4 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
 - 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
 - 3. Unilateral hip/thigh/knee/medial pain
- 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

- D. S1 nerve root compression, requiring ONE of the following:
1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
 3. Unilateral buttock/posterior thigh/calf pain
- (EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)
- II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:
- A. Nerve root compression (L3, L4, L5, or S1)
 - B. Lateral disc rupture
 - C. Lateral recess stenosis
- Diagnostic imaging modalities, requiring ONE of the following:
1. [MR](#) imaging
 2. [CT](#) scanning
 3. [Myelography](#)
 4. [CT myelography](#) & X-Ray
- III. 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](#) ([Fisher, 2004](#))

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)