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

Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 22, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for outpatient laminectomy at L3-4 with diskectomy, osteophytectomy, foraminotomy medial facetectomy.

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

M.D., Board Certified Orthopedic Surgeon

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 outpatient laminectomy at L3-4 with diskectomy, osteophytectomy, foraminotomy medial facetectomy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRI lumbar spine, 10/17/07
Office notes, Dr. , 1/22/08, 06/13/08, 08/26/08
Lumbar CT/myelogram report, 3/17/08
Peer review, Dr. , 9/8/08
Peer review, Dr. , 9/23/08

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Low back: Laminectomy/discectomy

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old female who was involved in a work related motor vehicle accident on xx/xx/xx. The claimant treated for cervical and lumbar pain following injury. A 10/17/07 MRI of the lumbar spine demonstrated minimal disc bulge at L4-5 and L5-S1. The claimant treated conservatively and came under the care of Dr. on 01/22/08. At that time she had findings of cervical cord compression and underwent anterior cervical discectomy and fusion at C4-5, C5-6 and C6-7 on 05/12/08.

The 03/17/08 lumbar CT scan post myelogram demonstrated multilevel degenerative disc change and facet/ligamentum hypertrophic change. There was foraminal narrowing on the left at L3-4 as a result of asymmetric disc bulge and facet/ligamentum hypertrophic change. The 03/17/08 lumbar myelogram demonstrated a 3 mm diffuse posterior protrusion of the disc/annulus at L3-4 and a 2 mm diffuse posterior protrusion of the disc/annulus at L4-5. Axillary sleeves and nerve roots filled symmetrically with no evidence of amputation or impingement.

Dr. evaluated the claimant on 06/13/08 for increased low back pain. On exam she had good strength of the upper and lower extremities and two plus knee reflexes and intact sensation. She stated that she was bending over on her knees when she developed a pain that ran from her back down her left leg to just above her left heel. Dr. felt she had aggravated the L3-4 disc. She was placed on Lyrica.

At the 08/26/08 visit the claimant complained of low back pain radiating into left leg with numbness. She was taking Lyrica, Robaxin and Darvocet. On exam she had bilateral paraspinous muscle spasms and tenderness of the interspinous ligament at L3-4 and L4-5 and tenderness of the left sacroiliac area. Pin prick sensation was decreased over the lateral big toe. Straight leg raise on the left produced back, hip and left leg pain at 65 degrees. There was no weakness. The impression was intervertebral disc displacement lumbar L3-4 basically toward the left with foraminal stenosis on the left side. There was also facet ligamentum hypertrophy and intervertebral disc displacement at L4-5 and L5-S1. The physician recommended lumbar laminectomy at L3-4 (possibly L4-5 and L5-S1 as well) with discectomy, osteophytectomy, foraminotomy, medial facetectomy and decompression of nerve roots on the left side. The surgery was denied on peer review.

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

The evidence-based literature suggests that individuals can be considered reasonable candidates for discectomy and laminectomy in the face of symptoms attributable to a specific nerve root and for whom imaging studies would be consistent with neural compression. Individuals should have failed conservative care and should also have corroborative physical examination findings.

In this particular case, this individual's original imaging studies described nothing more than a physiologic bulge at L4-5. Reportedly, the diagnosis was left lower extremity radiculopathy. Subjective decreased sensation was documented in the left foot in an L5 and S1 distribution although some sensory abnormalities were also documented across multiple dermatomes throughout the leg.

Subsequently, a CT myelogram showed no significant neural compression at L4-5 or L5-S1 and described some degree of neural foraminal narrowing at L3-4.

The request is to perform decompression at L3-4 as well as explore multiple levels. The clinical records do not clearly establish the diagnosis of radiculopathy and/or consistently identify findings or features that would explain her pain complaints based on L3-4 neural compression. As such, this reviewer would support the previous adverse determinations regarding the medical necessity of single-level decompression and/or exploration of multiple levels in this particular case. The reviewer finds that medical necessity does not exist for outpatient laminectomy at L3-4 with diskectomy, osteophytectomy, foraminotomy medial facetectomy.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Low back: Laminectomy/discectomy

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)**