

P-IRO Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: October 20, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for laminectomy, facetectomy, and foraminotomy (Unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s)), (e.g. spinal or lateral recess stenosis), single vertebral segment

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Office notes, Dr. 5/17/04, 02/10/05, 05/24/05, 07/25/05, 05/01/06, 09/15/06, 09/19/06, 11/21/06, 12/11/06, 01/08/07, 01/22/07, 05/01/07, 08/14/07, 12/07/07, 04/22/08, 04/29/08, 06/02/08, 06/13/08, 06/16/08

Procedure note, 6/29/04

Letter of medical necessity, 5/17/05, 07/25/08

CT myelogram/Post CT, 7/12/05

Pre-op H&P, 10/17/06

Surgery, 11/8/06

MRI, 5/24/08

Peer reviews, 8/1/08, 08/20/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who underwent left L4-5 hemilaminectomy on xx/xx/xx for left sided back and left lower extremity radicular symptoms from disc herniation. The claimant was seen regularly for occasional flare up of pain alternating from left to right lower extremity pain and back pain. Neurological exam findings remained normal. Treatment included pain medications, Medrol dose pack on occasion.

The claimant presented on 04/29/08 with increased bilateral leg pain, left greater than right. MRI on 05/24/08 noted postoperative changes at L5-S1 with severe bilateral facet hypertrophy and foraminal stenosis and partial lumbarization of S1 with the last disc labeled as S1-2. At L4-5, there was left foraminal and far lateral annular bulge with no nerve root impingement, stenosis or focal protrusion. Recent exam findings noted continued right lower extremity pain to just above the knee with minimal left leg pain and mild weakness bilaterally of the EHL.

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

The MRI on 05/24/08 was reviewed demonstrating primarily change in the left side, but subjectively throughout the recent office visits, right-sided pain was documented. Given this discrepancy, his subjective complaints do not match up with the objective findings in the postoperative spine. Without significant neural compressive lesion, cauda equina syndrome, further surgery is not indicated and appropriate.

Official Disability Guidelines Treatment in Worker's Comp 2008 Update, Low Back 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)**