MRI

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Notice of Independent Review Decision

DATE OF REVIEW: 4/14/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE The service under dispute includes a lumbar microdiscectomy with additional level; insertion of spinal prosthetic device and implant of spinal canal catheter at L3/4.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer performs similar types of services in daily practice.

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)

The reviewer agrees with the previous adverse determination regarding all services under review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]: This case involves a female who injured her left groin pulling and lifting while on the job. She underwent extensive workup and treatment and lumbar laminectomy and discectomy L3/4 on xx-xx-xx without benefit and with probable wound infection and drainage (WBC 15.2 and ESR 96 on 10/07). She was treated with IV antibiotics. She completed a chronic pain management course. Dr noted on 1/27/09 the presence of low back and bilateral leg pain with bilateral straight leg raising test positive and normal sensation, with L5 and S1 radiculopathy. MRI shows bulging of L3/4 disc.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. This patient has a variably reported physical exam and findings. She has duplicated treatment and seen multiple providers, completed a chronic pain management course and continues to seek further new treatment. Previous surgery of the similar/same type and location was of no benefit, and repeat surgery 20 months later has no added value according to the reviewer.

The ODG does not address all the aspects of this very extended and convoluted case. However, the ODG indicates the following are requirement criteria for a

lumbar laminectomy/discectomy. 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

(EMG's 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. Myelograpy
4. CT myelographyy & X-Ray

III. <u>Conservative Treatments</u>, requiring ALL of the following:

A. Activity modification (not bed rest) after patient education (>= 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 (chiropractor or massage therapist)
3. Psychological screening that could affect surgical outcome
4. Back school

Regarding patient selection, the reviewer doesn't feel this patient is a proper candidate at this time based upon the following ODG information. Microdiscectomy for symptomatic lumbar disc herniations in patients with a preponderance of leg pain who have failed non-operative treatment demonstrated a high success rate based on validated outcome measures (80% decrease in VAS leg pain score of greater than 2 points), patient satisfaction (85%), and return to work (84%). 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 than 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.

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)**