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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 08/18/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Laminectomy and discectomy at L3-L4 and L4-L5 with a one day length of stay

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

Board Certified in Orthopedic Surgery

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.

Laminectomy and discectomy at L3-L4 and L4-L5 with a one day length of stay - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY

On 07/23/08, Dr. recommended an occupational/physical therapy evaluation, a psychological evaluation, pain medication, MRIs of the cervical and lumbar spine, bilateral ankles and feet, and a neuromuscular electrical stimulator unit. MRIs of the lumbar spine, left foot, right foot, left ankle, and right ankle interpreted by Dr. on 07/31/08 showed multilevel degenerative changes in the lumbar spine, prominent varicosities in the left tarsal tunnel, osteoarthritic changes in the right first metatarsophalangeal (MTP) joint, and a small lateral talar dome osteochondral lesion with peroneus brevis tendinosis or limited intrasubstance tearing. Physical therapy was performed with Dr. from 08/04/08 through 11/21/08 for a total of 17 sessions. An EMG/NCV study interpreted by Dr. on 08/25/08 revealed non-specific mid-to-lower lumbosacral paraspinal musculature membrane irritabilities and a decreased recruitment pattern with no fast firing motor units, most likely related to a lack of effort versus an upper motor neuron process. Individual therapy was performed on 09/02/08, 09/03/08, and 09/10/08. A lumbar myelogram CT scan interpreted by Dr. on 06/01/09 revealed canal stenosis at L3-L4 and L4-L5 and a disc protrusion or bulge at L2-L3. Work conditioning was performed from 06/14/09 through 07/17/09 for a total of 20 sessions. On 06/18/09, 07/07/09, and 07/23/09, Dr. recommended lumbar spine surgery. On 06/29/09, Dr. wrote a letter of non-authorization for the lumbar surgery. On 07/17/09, Dr. wrote a letter of non-authorization for lumbar surgery.

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

The patient is not complaining of a radicular pattern. He has complaints of pain in his back, consistent with his arthritis. He has pain in his feet, also consistent with the arthritis demonstrated on multiple imaging studies. Electrodiagnostic studies are negative for radiculopathy. While the patient does have radiological findings of spinal stenosis, there are no physical findings or symptoms consistent with radiculopathy. Therefore, a lumbar laminectomy and discectomy is neither reasonable nor necessary. The lumbar procedure will not change the effects of the lower back pain and there is no evidence of radiculopathy. Therefore, the requested laminectomy and discectomy at L3-L4 and L4-L5 with a one day inpatient length of stay is neither reasonable nor necessary and the previous adverse determinations should be upheld.

The criteria utilized include the ODG criteria which requests objective evidence of radiculopathy before a laminectomy and discectomy to be performed, as well as multiple references in the scientific literature that demonstrate the utility of a decompression for lower back pain.

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 AND KNOWLEDGE BASE
- 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)**