

# MEDR X

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 12/7/2009

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The services under dispute include a laminotomy (hemilaminectomy) with decompression of nerve roots, including partial facetectomy, foraminotomy and/or excision of intervertebral discs, re-exploration, single interspace; lumbar spine with 2 day LOS.

### **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 has been practicing for greater than 15 years and performs this type of service 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 disagrees with the previous adverse determination regarding the prospective medical necessity of a laminotomy (hemilaminectomy) with decompression of nerve roots, including partial facetectomy, foraminotomy and/or excision of intervertebral discs, re-exploration, single interspace; lumbar spine with 2 day LOS.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
and Dr.

These records consist of the following (duplicate records are only listed from one source):  
Records reviewed : 9/28/09 denial letter, 11/10/09 denial letter, 9/27/09 peer review by DO, 11/10/09 peer review by MD, undated preauth request, undated preauth request (appeal) and 8/17/09 report by Dr.

Records reviewed from Dr. : neurological evaluation/follow up reports (typewritten and handwritten) from 1/15/09 to 11/16/09, 8/25/09 lumbar MRI report, 3/31/09 lumbar MRI report, 1/15/09 handwritten history form, 5/13/09 tissue consult report, 12/17/08 lumbar CT scan report, 12/16/08 xray reports of T and L spine, refill requests from 6/8/09 to 11/3/09, PT reports from 2/16/09 to 8/13/09, 2/26/09 PT script, 5/13/09 discharge summary from Hospital , 5/13/09 operative report and 5/13/09 history and physical report.

We did not receive a copy of the ODG Guidelines from Carrier/URA.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to Dr. 's records, the claimant was treated for back pain with left-sided radiculopathy and was status post L5-S1 discectomy on 5-13-09. The pre-operative work-up had included a clinical evaluation (including decreased sensation in an L5-S1 distribution, a positive straight leg raise bilaterally and MRI scan positive for a disc protrusion with nerve root displacement.

Postoperatively, recurrent (moderately severe) back and left leg pain were documented. A bilateral positive straight leg raise, "some cross straight leg raising" decreased sensation in the S1>L5 dermatomes, sciatic notch-popliteal fossa tenderness, muscle spasms, plantar flexion weakness, a "slightly decreased Achilles reflex" and a dysfunctional gait were noted three months post-op. A post-operative MRI revealed findings consistent with a central and "large recurrent" disc L5-S1 disc herniation with lateralization to the left. The claimant was noted to have not significantly responded to physical therapy, medications epidural steroid injections and to have "..failed conservative therapy." The claimant was considered for a repeat laminectomy-discectomy and a two day overnight hospitalization.

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

The following excerpt from the ODG Guidelines references the specific application of these Guidelines to this specific case. ODG Guidelines are fully applicable in this case.

ODG Indications for Surgery -- Discectomy/laminectomy --

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

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. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

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.)

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

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):
  - Physical therapy

The claimant has clear documentation of a combination of radiculopathy with + imaging findings compatible with recurrent disc pathology at L5-S1. Non-operative post-operative treatment as per ODG (consisting of activity modification, medications and therapy) has failed and the clinical presentation continues to be present and of at least moderate severity. ODG Guidelines support surgical intervention when there is clear documentation of a (recurrent) disc herniation with nerve root impingement with non-responsive radiculopathy. The proposed surgical procedures are therefore reasonably required as requested.

**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)**