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Notice of Independent Review Decision

DATE OF REVIEW: 11/11/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Laminotomy, foraminotomy, discectomy L4-5/L5-S1

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

Texas Board Certified Orthopedic Spine
Practicing Neurosurgeon

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. IRO referral form.
2. Peer review dated 02/06/09 by Dr.
3. Procedure report lumbar myelogram with post myelogram CT, 08/06/09.
4. Adverse determination notice for preauthorization request for laminotomy, foraminotomy, discectomy L4-L5/L5-S1, 09/30/09.
5. Adverse determination after reconsideration notice request for laminotomy, foraminotomy, discectomy, 10/15/09.
6. Letter response to request for IRO 10/28/09.
7. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female who reportedly was injured on xx/xx/xx when she was carrying and tripped over box causing her to strain her low back area.

An MRI of the lumbosacral spine from 01/16/08 was noted to show mild degenerative disc disease at multiple levels. Plain radiographs were noted to reveal mild narrowing at L4-L5 and L5-S1.

Electrodiagnostic testing performed on 05/23/08 suggested possible sensory radiculopathy.

The employee was treated conservatively with medications, injection therapy, and TENS therapy.

Selective nerve root blocks performed 07/02/08 and 08/27/08 with no significant benefit noted.

Physical examination on 04/29/09 reported intact muscle strength and straight leg raise in seated supine position on right producing low back pain to the knee. Achilles and patellar reflexes were 0 bilaterally. The employee was noted to have antalgic gait on the right. Range of motion was very limited in flexion/extension.

A CT myelogram of the lumbar spine dated 08/06/09 revealed minimal disc bulging present at L4-L5 with moderate right facet hypertrophy present. There was moderate right neural foraminal narrowing at this level. At L5-S1, there was diffuse annular disc bulging present with mild facet hypertrophy. There was mild right neural foraminal narrowing at that level. There was no evidence of central canal stenosis.

A request for laminotomy, foraminotomy, discectomy L4-L5/L5-S1 was reviewed by Dr. on 09/30/09. The proposed surgical procedure was non-authorized, noting an MRI and CT myelogram failed to reveal any evidence of significant neural compression. Physical examination findings were suggestive of radiculopathy; however, given the lack of neural compression by diagnostic tests coupled with evidence on examination of radiculopathy, the requested surgical intervention was not seen as medically necessary.

A request for reconsideration was reviewed by Dr. on 10/15/09. The reconsideration request again was not authorized. Dr. noted that the employee was noted to have normal reflexes but decreased EHL bilaterally and dysesthesia in both first and fifth toe noted per discussion with PA. A follow-up evaluation on 09/24/09 noted continued complaints of low back pain radiating to right buttock posterolateral anterior thigh right leg just past the knee. Selective nerve root block on right was noted to have been quite helpful for few days, but exact nerves blocked were not described. Lumbar facet injections were not helpful. The employee was noted to have lumbar range of motion significantly diminished with good lower extremity strength except EHL weakness 4/5 bilaterally. Patellar deep tendon reflexes were diminished bilaterally and Achilles deep tendon reflexes were present and symmetrical. Diminished sensation was noted in both first and fifth toes in right foot and lateral leg. Dr. noted the employee's physical examination findings did not correlate with both levels being pathological.

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

Medical necessity is not established for the proposed surgical procedure with laminotomy, foraminotomy, and discectomy L4-L5/L5-S1. The employee was noted to have sustained an injury to low back secondary to tripping over box on xx/xx/xx.

Imaging studies revealed multilevel degenerative changes of lumbar spine. CT myelogram dated 08/06/09 revealed minimal disc bulging present at L4-L5 with moderate right neural foraminal narrowing. At L5-S1, there was diffuse annular disc bulge present with mild facet hypertrophy and mild right neural foraminal narrowing. There was no evidence of spinal canal stenosis, and no clear evidence of nerve root compression. Per a peer review report of 02/06/09, the employee had been determined to have reached Maximum Medical Improvement (MMI) as of 03/25/08 with a 0% whole person impairment rating. The report noted the employee's imaging studies revealed mild degenerative changes in lumbar spine consistent with age and body habitus.

Given lack of objective findings of significant neural compressive pathology, surgical intervention is not indicated as medically necessary. As such, previous determinations of non-authorization were appropriate and should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ODG Treatment Integrated Treatment/Disability Duration Guidelines, Low Back chapter, Online Version

Discectomy/ laminectomy

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
- D. 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](#) (chiropractor or massage therapist)
 - 3. [Psychological screening](#) that could affect surgical outcome
 - 4. [Back school](#) ([Fisher, 2004](#))