

SENT VIA EMAIL OR FAX ON
Nov/05/2009

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

Amended 10/10/09
Date of Notice of Decision: Nov/05/2009

DATE OF REVIEW:
Nov/03/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar Laminectomy / Discectomy L3/4, L4/5, L5/S1 Bilateral Lateral Recess
Decompression L5/S1 and Lumbar Corset

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
PT note, 07/02/09
Electromyography, 07/19/09
MRI lumbar spine, 07/22/09
Office note, Dr. 08/18/09
Peer review, 10/02/09
Peer review, Dr. 10/02/09

PATIENT CLINICAL HISTORY SUMMARY

This is a male with complaints of low back pain to his posterior buttocks associated with numbness and tingling to the soles of his feet. The MRI of the lumbar spine from 07/22/09

showed at L5-S1, there was central posterior disc herniation measuring 4.7 millimeters (mm) in AP diameter, hypertrophic changes in the facet joints which caused moderate foraminal stenosis bilaterally, more prominent in the left. At L3-4 and L4-5 there was a broad sided posterior protrusion subligamentous disc herniation measuring 4.7 millimeters AP diameter touching the thecal sac. There was a tear in the posterior annulus fibrosus centrally at L4-5. The 07/19/09 electromyography was performed with samples taken from bilateral gastrocnemius, bilateral tibialis anterior and bilateral vastus lateralis muscles. Evidence of denervation was recorded from the right vastus lateralis muscles. Evidence of reinnervation was recorded from the bilateral tibialis anterior and right vastus lateralis muscles. The impression noted evidence of denervation/reinnervation process that involved the distal bilateral L5 and right L4 myotomes without clear proximal association to the corresponding lumbar nerve root level in the absence of the lumbar paraspinous EMG examination. Clinical correlation was recommended. There was evidence of left tibial motor mononeuropathy of uncertain etiology. Clinical correction was recommended. Clinical report of bilateral back pain and bilateral paresthesias was noted. Dr. evaluated the claimant on 08/18/09. Foot evener weakness to the right side consistent with S1 motor weakness was present. The diagnosis was lumbar disc herniation at L3-4, L4-5 and L5-S1, facet joint enlargement with recess narrowing a L5-S1 bilaterally and S1 motor weakness to the right side. The claimant has been treated with physical therapy.

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

The requested 3 level lumbar decompression cannot be justified as medically necessary based on the information reviewed. Though there is a single therapy note from 07/02/09, the extent of the prior physical therapy treatment is unknown. There is no other conservative care documented. In general, surgery should be reserved for claimants who fail conservative measures and there is insufficient information to justify the procedure and corset, based on the information provided.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, chapter low back, laminectomy/discectomy, laminectomy/laminotomy, and lumbar corset

- Lumbar Laminectomy/discectomy

ODG Indications for Surgery™ -- Discectomy/laminectomy –Radiculopathy, weakness/atrophy, EMG optional, Imaging for correlation with radicular findings. Activity modification of 2 months and at least one of the following; NSAIDs, analgesic, muscle relaxants, ESI. Must have **one** of the following PT, chiro. Psychological screening, back school. Diagnostic imaging modalities, requiring ONE of the following: MR imaging, CT scanning, Myelography CT myelography & X-Ray

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

ACOEM-AMERICA 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)