

MEDR X

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Notice of Independent Review Decision

DATE OF REVIEW: 10/25/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an inpatient left lumbar laminectomy and nerve root foraminotomies at L4 and L5 with 3 days 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. This reviewer has been practicing for greater than 10 years in this specialty and performs this type of procedure in his office.

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 the prospective medical necessity of an inpatient left lumbar laminectomy and nerve root foraminotomies at L4 and L5 with 3 days LOS.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from Inc.: Denial letter – 8/4/2009 & 8/24/09, Utilization Review Referral – 7/29/09; , MD MRI Report – 7/16/09; Utilization Review Referral Reconsideration – 7/29/09; , MD Electro-Diagnostic Interpretation – 5/19/09; Office Visit Notes – 4/30/08, PT script – undated, Operative Report – 4/11/08.

Records reviewed from Dr. : Office Note – 7/21/09; , MD Operative Report – 7/10/09.

Records reviewed were identical to Inc. records.

Records reviewed from : MD DDE report – 4/23/09; MD MMI/Impairment Rating Report – 12/11/07 & 6/11/08; MRI report – 2/4/08; MD Office Note – 6/6/08; report – 6/11/08; K. Fan, MD MRI report – 7/16/09.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx when struck by a forklift. Persistent pain resulted in an MRI L Spine which revealed an L4-5 left disc herniation. Failure of conservative care followed and the patient underwent an L4-5 left laminectomy and foraminotomy. The patient has persistent left leg pain and has undergone repeat MRIs w&w/o gadolinium and this reveals scar tissue at L4-5 on the left and a 2-3mm protrusion at L5-S1 with no nerve displacement. PT and ESIs have been of no benefit. An EMG is c/w L4 radiculopathy. He has documented normal motor strength and reflexes in the left leg.

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

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

Findings require ONE of the following:

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

(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

Diagnostic imaging modalities, requiring ONE of the following:

1. MR imaging
2. CT scanning
3. Myelography

The patient has no compressive lesion compatible with an L4 radiculopathy. Also the patient has no objective evidence of L4 radiculopathy and has epidural scarring that would account for L4 pain that would not be improved by decompression. There is no evidence of L5 radiculopathy is present. The proposed procedure does not meet ODG criteria and is therefore not medically necessary.

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)