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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jul/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right L5-S1 and Bilateral L4-5 Microendoscopic Lumbar Decompression right at L5-S1 and bilaterally at L4-5

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

MD, Board Certified in Neurological 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

2010 Official Disability Guidelines

, 5/27/10, 7/7/10

Spinal Clinic 1/11/08 to 5/14/10

Imaging 5/30/07-1/25/10

MD, 10/5/07-12/12/07

MD, 11/6/07

MD, JD, 1/30/08, 4/3/08, 11/20/08, 12/16/08, 5/26/09, 9/14/09, 7/30/09

TDI, DWC, Decision and Order, 6/18/09

TDI, 12/8/08

MD, 11/25/09

FCE, 9/8/09

MD, 10/09/07

MD, 1/20/09

PATIENT CLINICAL HISTORY SUMMARY

This is a female with a date of injury xx/xx/xx, when she fell backwards as she stumbled over supplies that were on the floor. She complains of pain radiating from the low back into the right buttock, down to the plantar aspect of the foot. She has some similar symptoms on the left, but they are worse on the right. In 2008 she complained the pain radiated down the anterior thigh. She has undergone ESIs, pain medications, and physical therapy.

Electrodiagnostic tests of 10/09/2007 were unremarkable. Her examination reveals decreased sensation in the right posterolateral calf and a positive straight-leg raising on the right. An MRI of the lumbar spine 01/25/2010 reveals at L1-L2 a moderate central and right paracentral disc protrusion impinging on the thecal sac and resulting in encroachment on the right lateral recess. At L4-L5 there is a disc protrusion far lateral to the left. This is mildly encroaching on the left L4 nerve root. At L5-S1 the disc mildly protrudes into the right neuroforamen and mildly encroaches on the right L5 nerve root. These findings are stable when compared to an MRI of the lumbar spine 10/11/2007.

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

The reviewer finds that Right L5-S1 and Bilateral L4-5 Microendoscopic Lumbar Decompression right at L5-S1 and bilaterally at L4-5 is not medically necessary.

The pain generator(s) are unclear. The claimant has no objective evidence of radiculopathy,

including her physical examination and electrodiagnostic studies. The neuroimaging at L4-L5 and L5-S1 demonstrates "mild" findings, and is unchanged from 2007. The worst level of nerve root involvement is at L1-L2, and the pattern pain radiation in 2008 was more in an upper lumbar nerve root distribution. It is not clear that there is not pain coming from this level. Without a clear radicular pattern of pain and/or any objective measures of radiculopathy, as well as neuroimaging demonstrating frank nerve root compression at L4-L5 and L5-S1, the procedure, as a whole, remains not medically necessary. This determination is consistent with ODG criteria.

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 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 (>= 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)

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)