INDEPENDENT REVIEWERS OF TEXAS, INC.

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DATE OF REVIEW: 12/01/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: LAMINECTOMY, FACETECTOMY AND FORAMINOTOMY (UNILATERAL OR BILATERAL WITH DECOMPRESSION OF SPINAL CORD, CAUDA EQUINA AND/OR NERVE ROOT(S), (EG, SPINAL OR LATERAL RECESS STENOSIS), SINGLE VERTEBRAL SEGME
RECONSIDERATION REQUEST RECEIPT DATE: 11/05/2010
Dates of Service from 10/14/2010 to 10/14/2010

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

Texas Board Certified Orthopedic Surgeon
Texas Board Certified Orthopedic Sports Medicine

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. 11/10/08 - MRI Lumbar Spine
2. 11/20/08 - Clinical Note - MD
3. 12/16/08 - Clinical Note - MD
4. 01/09/09 - Electrodiagnostic Studies
5. 01/13/09 - Clinical Note - MD
6. 02/06/09 - Clinical Note - Unspecified Provider
7. 02/13/09 - Clinical Note - MD
8. 02/19/09 - Clinical Note - MD
9. 02/25/09 - Clinical Note - MD
10. 02/27/09 - Clinical Note - MD
11. 03/11/09 - Clinical Note - MD
12. 03/25/09 - Psychological Evaluation - PhD

13. 04/13/09 - Lumbosacral Myelography
14. 04/13/09 - CT Lumbar Spine
15. 04/14/09 - Clinical Note - MD
16. 04/29/09 - Clinical Note - DO, PA
17. 04/29/09 - Clinical Note - MD
18. 05/15/09 - Clinical Note - MD
19. 06/03/09 - Procedure Report
20. 06/17/09 - Clinical Note - MD
21. 07/07/09 - Clinical Note - MD
22. 08/11/09 - Clinical Note - MD
23. 09/08/09 - Clinical Note - MD
24. 09/11/09 - Clinical Note - MD
25. 09/28/09 - Required Medical Evaluation
26. 10/08/09 - Clinical Note - MD
27. 10/27/09 - Designated Doctor Evaluation
28. 10/27/09 - Report of Medical Evaluation
29. 10/30/09 - Clinical Note - MD
30. 11/11/09 - Clinical Note - DO
31. 12/02/09 - Clinical Note - MD
32. 01/05/10 - Clinical Note - MD
33. 02/10/10 - Clinical Note - MD
34. 02/17/10 - Clinical Note - MD
35. 02/17/10 - Radiographs Lumbar Spine
36. 03/02/10 - Clinical note - MD
37. 03/22/10 - Clinical Note - MD, PA
38. 04/06/10 - Clinical Note - MD
39. 04/15/10 - Laboratory Results
40. 05/03/10 - Clinical Note - MD, PA
41. 05/04/10 - Clinical Note - MD
42. 06/08/10 - Clinical Note - MD
43. 06/16/10 - Clinical Note - MD
44. 07/06/10 - Clinical Note - MD
45. 07/23/10 - Impairment Rating
46. 08/03/10 - Clinical Note - MD
47. 08/30/10 - Clinical Note - MD
48. 08/30/10 - Radiographs Lumbar Spine
49. 09/07/10 - Clinical Note - MD
50. 09/30/10 - Clinical Note - MD
51. 09/30/10 - Manual Muscle Testing
52. 10/18/10 - Peer Review
53. 10/18/10 - Utilization Review
54. 10/27/10 - Peer Review
55. 10/29/10 - Utilization Review
56. 11/09/10 - Clinical Note - MD
57. 11/09/10 - Manual Muscle Testing
58. 11/09/10 - Peer Review

59. 11/10/10 - Utilization Review
61. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee sustained an injury on xx/xx/xx when he twisted while holding a fan and felt a pain in the low back.

An MRI of the lumbar spine performed 11/10/08 demonstrated multilevel degenerative change. At L3-L4, there was a moderate sized to a broad-based disc bulge with small posterolateral osteophytic spurs to the right. There was mild right foraminal and central stenosis. A broad-based disc bulge was present at L4-L5. There are mild facet degenerative changes. There was mild central stenosis present. At L5-S1, there was mild to moderate facet degenerative changes. A small disc bulge with small left posterolateral osteophytic spurs was present. There was moderate left foraminal stenosis.

Electrodiagnostic studies performed 01/09/09 revealed evidence of bilateral peroneal and tibial motor neuropathy, more severe on the right side, as well as right superficial peroneal and sural sensory neuropathy. There was evidence of relatively severe, chronic left L5 radiculopathy.

The employee was seen for psychological evaluation on 03/25/09. The employee complained of pain in the low back that extends into the left lower extremity. The employee reported pain and numbness in the right lower extremity. The employee rated the pain at 3 out of 10. Current medications included Tramadol 50 mg and Arthrotec 75 mg. The employee's Oswestry Pain Survey score was 48%. The employee denied any feelings of depression, anxiety, irritability, or anger. The employee was felt to be an appropriate candidate for surgical intervention.

Lumbar myelography performed 04/13/09 revealed anterior epidural defects at L3-L4 and L4-L5. There was high positioning of an IVC filter at T1-T2.

A CT of the lumbar spine performed 04/13/09 demonstrated moderate disc height loss at L1-L2 with no significant central canal or lateral recess stenosis. There was minor disc height loss at L3-L4 with a mild concentric annular disc protrusion present without significant central canal, lateral recess, or neural foraminal stenosis. Vacuum phenomenon was noted at L4-L5. A moderate concentric annular disc bulge was noted with some flattening of the anterior aspect of the thecal sac with no significant central canal or lateral recess stenosis. Vacuum phenomenon was present at L5-S1. There was no significant central canal or lateral recess stenosis. The neural foramina were patent bilaterally. Overall, there were no levels of significant central canal, lateral recess, or neural foraminal stenosis.

The employee underwent a caudal epidural steroid injection on 06/03/09.

The employee was seen for Designated Doctor Evaluation on 10/27/09. The employee complained of low back pain that radiated down the left leg with numbness of the entire left foot. There was numbness in the right leg from the knee down to the foot. The employee reported decreased libido due to pain. Physical examination revealed marked skin changes in the lower extremities due to circulation disturbances. There was decreased sensation to pinprick in the left S1 dermatome. There was weakness of the left extensor hallucis longus muscle. Straight leg raise was positive bilaterally. The employee was assessed with left S1 radiculopathy probably secondary to L5-S1 disc bulge and degenerative changes. The employee was not placed at Maximum Medical Improvement (MMI) at that time.

Radiographs of the lumbar spine performed 02/17/10 demonstrated retrolisthesis of L3 on L4, L4 on L5, and decreased disc space height at L5-S1.

The employee saw Dr. on 03/22/10. The employee reported difficult progression with ambulation and paresthesia in the lower extremities. The employee also reported erectile dysfunction. Physical examination revealed some edema of the lower extremities with significant chronic trophic skin changes due to chronic stasis in the lower extremities. Knee and ankle reflexes were absent. Sensory examination was diminished to pinprick in a stocking-glove distribution. The employee had difficulty walking due to pain. Flexion of the lumbar spine was restricted to 10 degrees maximum. The employee was sent for laboratory work.

The employee saw Dr. on 05/03/10. The note stated laboratory results were suspicious for a B12 deficiency. The employee was referred for endocrinology consultation and full B12-related workup.

The employee was seen for impairment rating on 07/23/10. The employee complained of back pain rating 8 out of 10 and numbness in the lower extremities. The pain worsened with bending, standing, lifting, pushing, and pulling. Current medications included Tramadol, Flexeril, and Arthrotec. Physical examination revealed sensory loss in the lower extremities with the left L5 and the right L4.

No updated imaging studies were submitted for review that provide additional findings of pathology that were consistent with the employee's objective examination findings.

The request for Laminectomy, facetectomy, and foraminotomy (unilateral or bilateral) with decompression of spinal cord, cauda equina, and/or nerve roots, (EG, spinal, or lateral recess stenosis) single vertebral segment was denied by utilization review on

10/29/10 due to lack of myelographic evidence of significant canal, lateral recess, or neuroforaminal stenosis that would reasonably be the cause of the employee's findings on physical exam. No updated imaging studies were submitted for review that provide additional findings of pathology that are consistent with the employee's objective examination findings.

The employee saw Dr. on 11/09/10 with complaints of low back pain rating 5 out of 10 on the visual analog scale. The pain radiated to both lower extremities. The employee also reported continued numbness and tingling in the feet bilaterally. Physical examination revealed tenderness in the lower lumbar region with decreased range of motion in all directions. The employee continued to have paresthesia in both shins and feet. There are marked skin changes in both lower extremities due to circulation disturbances. Motor strength remained weakened in the extensor hallucis longus . Straight leg raise was positive bilaterally. The employee was assessed with disc derangement of L4-L5, paracentral, L5-S1 on the left, with radiculopathy. The employee was to continue his current medications.

The request for Laminectomy, facetectomy, and foraminotomy (unilateral or bilateral) with decompression of spinal cord, cauda equina, and/or nerve roots, (EG, spinal, or lateral recess stenosis) single vertebral segment was denied by utilization review on 11/10/10 due to lack of evidence of central canal or lateral recess stenosis. There was no indication the employee had any compression of the nerve roots that would warrant lumbar discectomy or laminectomy at that time.

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

The employee was recommended for a laminectomy facetectomy, and foraminotomy to decompress the spinal cord at L4-L5 and L5-S1. The employee exhibits weakness in the lower extremities on physical examination and has not improved with conservative treatment. The CT Myelogram of the lumbar spine from 04/13/09 does not reveal any significant spinal canal or foraminal stenosis at the L4-5 or L5-S1 level that would require the requested surgical procedures. Current evidence based guidelines recommend that employees have consistent findings on imaging studies to warrant decompression procedures. As no updated imaging studies were provided for review, medical necessity is not supported.

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

Official Disability Guidelines, Online Version, Low Back Chapter