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### Notice of Independent Review Decision

**DATE OF REVIEW:** 6/7/10

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Bilateral laminotomy L4-5 with 1-day LOS

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

Certified by the American Board of Neurological Surgery

**REVIEW OUTCOME**

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	NDC	Upheld/ Overturned
		Prospective	847.2	63030	Upheld
		Prospective	847.2	63030	Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physician notes dated 4/28/10, 4/22/10

Procedure note dated 12/10/09

X-ray reports dated 4/22/10, 10/14/09

Official Disability Guidelines cited-Low Back Chapter

**PATIENT CLINICAL HISTORY:**

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The patient is a male whose date of injury is xx/xx/xx. Records reflect the patient was lifting a truck brake drum and experienced onset of low back pain. MRI of the lumbar spine done 10/14/09 revealed mild degenerative changes greatest at L4-5 with a small central protrusion. There is no significant spinal stenosis or neural foraminal narrowing. The patient was treated conservatively with physical therapy and lumbar epidural steroid injections without significant improvement. CT myelogram done 04/22/10 showed a shallow ventral defect at L4-5, defect resolved in flexion. Post myelogram CT revealed a 3-4 mm diffuse central disc protrusion reaching the dural sac at the level of origin of L5 nerve root sleeves without displacing the root sleeves. Mid sagittal dural diameter is about 8 mm. Physical examination reported tenderness to palpation of the lumbar spine. Range of motion testing reported lumbar testing 45 degrees, extension 10 degrees with increased low back pain, 10 degrees left and right lateral bending. Deep tendon reflexes were 1 and symmetrical in bilateral lower extremities. Motor strength was 5/5 throughout the bilateral lower extremities. Sensation to pin was equal and intact in the lower extremities. Straight leg raise at 45 degrees bilaterally produced lower back pain.

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

In the Reviewer's opinion, based on the clinical information provided, the request for bilateral laminotomy L4-5 with one day inpatient stay is not seen as medically necessary. The patient sustained a lifting injury to the low back in 09/09. His condition has been refractory to conservative treatment including physical therapy and epidural steroid injections. Imaging studies revealed mild degenerative changes at L4-5 with no significant stenosis or foraminal narrowing. CT myelogram revealed a diffuse central disc protrusion at L4-5 which reaches the dural sac at level of origins of L5 root sleeves without displacing the root sleeves. There is some stenosis noted with mid sagittal dural diameter of about 8 mm. On examination the patient has no evidence of neurologic deficit with motor strength 5/5 and sensation equal and intact throughout bilateral lower extremities, nor is there evidence of neurogenic claudication consistent with spinal stenosis. As such, medical necessity is not established for the proposed surgical procedure.

#### Reference:

2010 Official Disability Guidelines, 15<sup>th</sup> edition, Work Loss Data Institute, online version, Low Back Chapter.

#### Laminectomy/ laminotomy

Recommended for lumbar spinal stenosis. For patients with lumbar spinal stenosis, surgery (standard posterior decompressive laminectomy alone, without discectomy) offered a significant advantage over nonsurgical treatment in terms of pain relief and functional improvement that was maintained at 2 years of follow-up, according to a new SPORT study. Discectomy should be reserved for those conditions of disc herniation causing radiculopathy. Laminectomy may be used for spinal stenosis secondary to degenerative processes exhibiting ligamentary hypertrophy, facet hypertrophy, and disc protrusion, in addition to anatomical derangements of the spinal column such as tumor, trauma, etc. (Weinstein, 2008) (Katz, 2008) This study showed that

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surgery for spinal stenosis and for disc herniation were not as successful as total hip replacement but were comparable to total knee replacement in their success. Pain was reduced to within 60% of normal levels, function improved to 65% normal, and quality of life was improved by about 50%. The study compared the gains in quality of life achieved by total hip replacement, total knee replacement, surgery for spinal stenosis, disc excision for lumbar disc herniation, and arthrodesis for chronic low back pain. (Hansson, 2008) A comparison of surgical and nonoperative outcomes between degenerative spondylolisthesis and spinal stenosis patients from the SPORT trial found that fusion was most appropriate for spondylolisthesis, with or without listhesis, and decompressive laminectomy alone most appropriate for spinal stenosis. (Pearson, 2010) Laminectomy is a surgical procedure for treating spinal stenosis by relieving pressure on the spinal cord. The lamina of the vertebra is removed or trimmed to widen the spinal canal and create more space for the spinal nerves. See also Discectomy/laminectomy for surgical indications, with the exception of confirming the presence of radiculopathy.

### **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

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- 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)**