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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jul/14/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L3-4, L4-5 Lumbar Laminectomy & Foraminectomy *1 Day inpatient stay*

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

ODG (Low Back Chapter)

Intracorp, 4/26/10, 5/21/10

Clarus 11/25/09

Brain and Spine Institute 1/5/10, 1/6/09, 5/26/09, 6/21/07, 6/10/10

Diagnostic Radiology 4/18/07, 12/12/06

Sunrise Chiropractic 11/27/06

Diagnostic 2/4/08

attorney 1/9/08

M.D. 5/16/07

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury xx/xx/xx when he had a hoist and tire assembly fall on him. He complains of back and bilateral leg pain, and dragging his left leg when he walks. He has undergone ESIs, medication and therapy. A neurological examination 06/21/2007 revealed decreased sensation to the left leg. Electrodiagnostic testing 05/16/2007 revealed a right peroneal motor mononeuropathy at the fibular head, mild generalized peripheral neuropathy and no clear evidence of lumbar radiculopathy. An MRI of the lumbar spine 11/25/2009 reveals at L3-L4: 1-2mm of anterolisthesis. There is a 2-3mm broad-based left foraminal disc bulge causing mild left foraminal narrowing, with minimal flattening of the left L4 nerve root. At L4-L5 there is a minimal annular disc bulge that flattens the ventral thecal sac. No nerve root impingement is identified.

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

The surgery is not medically necessary. There is no objective evidence of radiculopathy on examination, as well as no electrodiagnostic evidence of radiculopathy. Moreover, there is no nerve root compression seen at L4-L5. There is just a minimal central disc bulge. According to the ODG, "Low Back" chapter, there should be "concordance between radicular findings on radiologic evaluation and physical exam findings". In this case there is not at L4-L5. Upon independent review, the reviewer finds that the previous adverse

determination/adverse determinations should be upheld. The reviewer finds that medical necessity does not exist for L3-4, L4-5 Lumbar Laminectomy & Foraminectomy *1 Day inpatient stay*.

References/Guidelines

2010 Official Disability Guidelines, 15th edition

"Low Back" chapter

Occupational and Disability Guidelines, "Low Back" chapter

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. (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)