



MedHealth Review, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: 3/15/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a re-explore laminectomy @ Lt L3-L4, L4-L5 left with 2 days LOS (63042 & 63044).

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 15 years.

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 medical necessity of a re-explore laminectomy @ Lt L3-L4, L4-L5 left with 2 days LOS (63042 & 63044).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Sports Medicine

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Sports Medicine Centre: Reconsideration request – 11/23/09, 1/8/10, & 2/2/10, letter – 10/8/09(x2) & 10/31/09, Surgery Scheduling – 10/6/09, Operative report – 12/21/09, X-ray report – 10/12/09; MD DDE report – 1/14/10 & 2/17/10; MD EMG report – 12/8/09; MD radiology report – 4/15/09; DC office notes – 7/23/09; MD letter – 6/16/09, EMG report – 3/10/09; Spine & Rehab Center PT notes – 12/10/08 - 4/3/09; Dr. Progress Reports – 8/27/08-12/17/08; Pain & Recovery Center Notes – 9/26/08-11/10/08. Records reviewed from Health Care: Spine & Rehab Center PT notes – 2/3/09-4/3/09, PT Soap Note – 12/17/08-4/14/09, Initial Exam – 9/23/08, Progress note – 9/23/08, Script – 9/23/08, Request for Pre-Auth – 1/14/09; Therapy Flow Sheet – 3/17/09-4/2/09.

We did not receive WC Network Treatment Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

On XX/XX/XX, a Dr. noted the claimant's old prior history of laminectomies L3-S1. In 8/08, the claimant had a reported new injury due to a slip and fall. Recurrent disc pathology vs. scar was noted on an MRI from 9/08. Despite the passage of time and therapy, the claimant has had persistent back pain. "Non-dermatomal" left leg numbness was noted. A 4/15/09 dated MRI did not reveal definite nerve root impingement while an electrical study from 12/8/09 revealed a chronic S1 radiculopathy. On exam an absent left ankle reflex was noted along with weak ankle plantar flexion and left great toe extension. One + Waddell test was noted. On 1/14/10, acute L5 radiculopathy and chronic left S1 radiculopathy were felt applicable. Surgery was felt indicated. The reconsideration letter of 1/8/10 was noted with L5 and S1 radiculopathy and failure of medications, injections and therapy. The corroborating electrical study was noted from 12/21/09. The AP notes including appeal from 10/31/09 were noted. The claimant was felt to have an indication for decompression at 3 levels for the "radicular component." The 4/15/09 dated MRI report's most prominent finding was that of nerve root impingement at L3-4 of the L3 nerve roots. The dated denial review was noted with rationale that L3-4 did not have a documented lesion warranting decompression. The 1/22/10 dated denial review was noted with lack of ESI-associated results.

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

There has not been documented evidence of active radiculopathy at the L3-4 level. There has not been documented symptoms, exam and/or electrodiagnostic findings compatible with nerve root impingement at that level. Therefore the aggregate of procedures at that level and adjacent as proposed overall, are not reasonably required.

Reference: ODG Guideline 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:

- 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- 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)