

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 3, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

63047 – Removal of Spinal Lamina
63048 – Remove Spinal Lamina Add-on

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

This physician is a Board Certified Orthopedic Surgeon.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On March 22, 2001, the claimant was seen by, MD for follow up visit for severe left leg pain which was originally seen the same date by Dr.. Recorder states that the pain was

so severe that claimant cannot sit or stand for a prolonged period of time. He has no symptoms on the right side, no bowel or bladder dysfunction or weakness. Physical exam was completed, diagnostic studies included a lumbar MRI scan which showed a large disc herniation, most notably at L 4/5 which has extended superiorly. Impression was severe left radicular pain from large disc herniation with free fragment. Treatment plan indicated in the report was a micro-discectomy.

On March 15, 2001, an MRI of Lumbar Spine WO/Contrast was performed. The impression was large herniated disc at L4-5 with an extruded fragment extending from the level of the L4-5 disc superiorly to the left of the midline and into the left L4 neural foramen.

On April 16, 2001 a consultation procedure was performed for the purpose of a Workman's Comp Second Surgical Opinion by, M.D. Impression and plan from the review indicate left L4-5 disc herniation with rostral migration and that claimant appeared to have a left L5 radiculopathy. Options discussed were surgical versus non-surgical and claimant wished to proceed with surgery. Dr. concurred that surgery was reasonable and necessary.

On May 15, 2011 surgery was performed. Pre-op diagnosis was L4-5 herniated disc. Post-op diagnosis was L4-5 herniated disc. Operation performed was Left L 4-5 micro-discectomy.

On July 26, 2001 a follow up visit was performed by, M.D. Follow up report indicate that claimant had done very well since surgery and that most of his symptoms had completely resolved. Dr. declared claimant at MMI and would get a FCE and Impairment Rating. Dr. released the claimant from further scheduled follow up.

On August 17, 2001 Medical Evaluation for Impairment Rating was performed. The report states that claimant received an 11% impairment rating. 10% of the impairment was for surgically treated disc lesion, with residuals and 1% was attributed to a limited ROM.

On August 17, 2001 the claimant completed a Functional Capacity Evaluation. FCE performance stated that claimant demonstrated the ability to perform with a MEDIUM work category. Recommendation were that claimant perform within a MEDIUM work category with the maximum demonstrated lift of 50 pounds on an occasional basis from 10" from floor to waist height, 30 lbs from waist to shoulder height, and 30 lbs from floor to shelf carry. Also recommended was that the claimant follows the guidelines as set on the FCE and recommended that the claimant continue to self-manage his pain symptoms with the use of good body mechanics and posture. Recommendations were reviewed with claimant.

On September 24, 2001 the Report of Medical Evaluation was completed by , MD stating that maximum medical improvement was reached 7-26-2001. The claimant was given an Impairment Rating of 11%.

On June 27, 2007 claimant was referred to, M.D. by Dr. , D.O. for evaluation of low back and left leg pain. Physical Examination: Positive left SLR. There is decreased sensation to light touch over the left dorsal foot and lateral foot. DTRs trace bilateral patellar tendon and Achilles tendon but no ankle clonus. Impression was 1) Left leg pain consistent with S1 radiculopathy with some involvement of the L5 spinal nerve, 2) related to probable recurrent disc herniation at L5-S1 related to claimant's initial work related injury, 3) no evidence of myelopathy, 4) no evidence of deep venous or other peripheral vascular pathology. The plan states claimant was to increase exercise level, avoid lumbar flexion and rotation, fluoroscopically guided left L5-S1 selective epidural to treat radiculopathy pain and that at this time there is no need for surgery, Dr. states that if this provided good relief "we are done", "if it does not then I will request an MRI of the lumbar spine to rule out more ominous pathology. A new MRI is not indicated at this juncture."

On August 3, 2007 the claimant received a Transforaminal Epidural Injection at Joint by MD. The Transforaminal epidural level treated was left L5 spinal nerve at L5-S1 and left S1 spinal nerve at S1.

On April 21, 2008 the claimant was seen in Dr. office related to the new onset of severe left leg pain radiating from his buttock to his entire foot. Dr. states that the claimant had similar symptoms over one year ago and successfully treated with a single epidural injection. Dr. states that a Lumbar MRI demonstrates a large posterior L5-S1 disc herniation. Impression was 1) Recurrent left leg pain related to initial injury in xxxx. These symptoms are the exact distribution and the disc likely re-tore at L5-S1 level based on presentation. Recommendations were 1) no indication for surgery, 2) no indication for MRI. "I am trying to provide him with relief with minimal cost.", 3) will request authorization to perform a single fluoroscopic guided left L5-S1 selective epidural to treat chemical radiculopathy pain., 4) if the epidural did not provide relief than I would request an MRI to rule out more ominous pathology., 3) prescribed Norco 10 mg q 4-6 h p.r.n. and (claimant) to call if refill needed., 6) claimant was given recommendations for an aggressive independent exercise program.

On August 18, 2008 the claimant received a Lumbar Transforaminal Epidural Injection: L5-S1 left at Joint by, MD.

On June 22, 2009 the claimant was seen by, MD for an Established Office Visit. Physical Examination: Positive SLR on the left. Decreased sensation in left Extension Hallucis Longus muscle. The impression was left S1 and left L5 Radiculopathy, L5/S1 Herniation, kidney disease. Plan states recommend L5/S1 Discectomy utilizing the Deckompressor Technology, 2. Prescription of Tramadol 50 mg to be taken 1 to 2 every 6 hours for pain, 3 taught patient how to do Independent exercises at home.

On September 14, 2009 claimant was seen in by, MD for an established office visit. Impression was 1) left L4 and L5 radiculopathy, 2) ambulatory dysfunction. The plan

was 1) recommend an MRI of the lumbar spine, 2) if claimant has a herniated disc, then the recommendation was for surgical or non-surgical decompression.

April 14, 2010, October 9, 2010, October 28, 2010 progress notes were sent.

On April 19, 2010 a referral was made to to consult and treat for claimant's back pain.

On October 27, 2010 MR Lumbar Spine W/O was performed indication was back pain, claimant indicated inability to walk or lay down too long and cannot lie in one position a long time. MRI revealed moderate facet hypertrophy at multiple levels including L2-3 and L3-4. A partial left hemilaminectomy was noted at L4-5 was noted at L4-5. A discal remnant was noted at this level causing narrowing of the spinal canal in the dura. There were no findings at L5-S1.

On January 3, 2011 was seen by, M.D. for lower back pain that radiates down the left leg. The claimant is hyporeflexic in both extremities. Sensation is intact. Impression was probable left radicular pain from lumbar spondylosis. From the standpoint of (claimant's) gait difficulty and urinary incontinence, MD expresses concern about the possibility of cervical stenosis and even normal pressure hydrocephalus.

On February 18, 2011, D.O., a neurosurgeon, performed a UR on the claimant. Rationale: The claimant presented with low back pain with no associated motor and sensory deficits. There is no clinical evidence of radiculopathy based on the latest findings.

On February 25, 2011, D.O., a neurosurgeon, performed a UR on the claimant. Rationale: No clear compression of the spinal canal was reported. The claimant's physical exam findings to reveal some hyperreflexia in the lower extremities; however, this appears to be a chronic finding and no new neurologic deficits are present.

PATIENT CLINICAL HISTORY:

The claimant is a, status post renal transplant in 2005, and CVA with right-side weakness, history of lacunar infarctions.

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

First, there are no new neurologic deficits that were noted on physical examinations. Secondly there is no evidence of radiculopathy per the recent clinicals submitted for review. Based on the above-mentioned the previous decisions are upheld.

PER THE ODG

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 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](#)) In patients with spinal stenosis, those treated surgically with standard posterior decompressive laminectomy showed significantly greater improvement in pain, function, satisfaction, and self-rated progress over 4 years compared to patients treated nonoperatively, and the results in both groups were stable between 2 and 4 years. ([Weinstein, 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. For average hospital LOS after criteria are met, see [Hospital length of stay](#) (LOS).

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)