



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 8/25/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar.

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. The reviewer has been practicing for greater than 10 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 prospective medical necessity of a laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant has had recurrent back pain with left sided radiation despite a prior decompression at L3-4 and L4-5 (with fusion at the later level, in February 2011.) The claimant had been involved in an MVA (car vs. claimant) in xxxx and subsequently underwent a decompression (in 2006) at L4-5 and L5-S1. The claimant has been considered for the proposed surgical intervention (including a fusion at L3-4). Mild retrolisthesis on a June 2011 dated CT scan has been noted (at L3-4.). There was also a disc-osteophyte complex suggestive of stenosis. The Attending Physician clinical notes, including the most recent operative summary, were reviewed. The claimant was noted to have an intact neurological exam on 4/26/11. "Stenotic radicular " complaints were noted on 5/24/11. The neurological exam was intact. The claimant had persistent significant pain on 7/5/11. Denial letters have noted the lack of a diagnostic block evidencing that the proposed abnormal L3-4 (radiographically) is a major pain generator. In addition, the lack of provision of flexion-extension films has also been noted. Finally, the lack of a recent physical examination and therapy trial has been noted.

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

The claimant has been noted to have primarily persistent back pain with some degree of radiation. However, a specific trial of medication and "physical medicine"/therapy with detailed response (or lack thereof) to such a non-operative trial has not been evidenced in the recent records. In addition, there has not been submitted radiographic evidence of segmental "spinal instability" at the proposed level of fusion L3-4. Finally, a recent psychosocial screen (with any potential "confounding issues" eliminated) has not been evidenced within this

record. According to the ODG, the requested service is not medically necessary at this time.

ODG Lumbar Spine Chapter-Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. (Colorado, 2001) (BlueCross BlueShield, 2002)

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)**