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Notice of Independent Review Decision

DATE OF REVIEW: 08/15/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4-L5 laminectomy and decompression

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

Board Certified in Orthopedic Surgery

REVIEW OUTCOME

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

X 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.

L4-L5 laminectomy and decompression - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 05/18/09, 07/21/09, 08/11/09, 04/05/11, 04/13/11, and 04/27/11
A History and Physical dated 04/06/11 from an unknown surgeon (the signature was illegible) from Surgery Center
A lumbar myelogram and post myelogram CT scan dated 04/25/11 and interpreted by M.D.
A follow-up evaluation with M.D. at Associates, L.L.P. on 05/03/11 and 07/13/11
Notifications of Determination dated 05/12/11 from R.N. at addressed to Dr. the patient, Hospital, and
Additional Notifications of Determination dated 06/06/11 from, R.N. at the addressed to Dr., the patient, Hospital, and
An undated Precertification Request from Dr. for a laminectomy and decompression at L4-L5
The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

Dr. evaluated the patient on 05/18/09 and reviewed a right shoulder MRI. An arthroscopic rotator cuff repair was recommended. It was noted his lumbar spine was resolved. On 07/21/09, Dr. noted with respect to the lumbar spine, he still continued to have radicular complaints of pain down the left leg with straight leg raising symptoms. X-rays showed slight narrowing of the L5-S1 disc space, but otherwise was normal. An MRI of the lumbar spine was recommended. On 04/05/11, Dr. noted Dr. wanted the patient to pursue epidural steroid injections (ESIs) as opposed to taking out his hardware or investigating his neck further. On 04/13/11, the patient informed Dr. that the ESI he received provided relief for two days and then all the pain came back. Dr. felt the patient might have a physical compression to the root. A lumbar myelogram with post myelogram CT scan on 04/25/11 revealed disc and facet pathology that was the most significant at L4-L5 where there was circumferential narrowing produced by severe facet hypertrophy and mild disc bulging. There was mass effect upon the transversing right L5 nerve root by large facet spur. There was also moderate canal stenosis and lateral recess narrowing. There was disc and facet pathology at L5-S1 with mild foraminal narrowing without definite contact of the exiting nerve root sleeves. Mild disc pathology was seen at T11-T12, L2-L3, and L3-L4 with mild foraminal narrowing without mass effect on the exiting or transversing nerve roots. On 05/03/11, Dr.

reviewed the CT myelogram and recommended lumbar laminectomy and decompression. On 05/12/11, Ms. at provided an adverse determination for the lumbar laminectomy and decompression at L4-L5. On 06/06/11, Ms. provided another adverse determination from for the lumbar laminectomy and decompression at L4-L5. On 07/13/11, Dr. Kushwaha noted they would appeal the denial for the laminectomy and decompression at L4-L5.

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

The request for L4-L5 laminectomy and decompression is not medically reasonable and necessary based on the recommendations of the Official Disability Guidelines (ODG). These medical records do not describe all of the components that are required by the ODG to approve the recommended surgical procedure. A CT myelogram was obtained. Unfortunately, neither Dr. nor Dr. described the path of his pain in any fashion other than to say he has right leg pain. It is not indicated whether this is posterior pain, lateral pain, or thigh pain, each of which are in different distributions. The second failure of these records is to document that there was any conservative care other than the single failed ESI. Dr. documented that the ESI did not yield good results, in that there were very short term results of only two days. That is a bad prognostic sign and does not suggest that surgery is necessary or will be successful.

Further, there is no adequate description of the physical examination. Dr. examination on 05/03/11 demonstrated decreased range of motion with pain on motion of his back. There was no neurological examination. There was no description of sensory or motor deficits. (One would not expect straight leg raising sign to be positive in spinal stenosis, but it is not documented as having been performed.) However, on 07/13/11, Dr. notes that there is decreased range of motion of the back with spasm and straight leg raising sign, which is positive on the right, which is not consistent with the findings from spinal stenosis as noted above. Again, the description of the pain, although severe, does not meet the requirements of the ODG at this time. Therefore, the requested L4-L5 laminectomy and decompression is neither reasonable nor necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE**

- [ ] 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
- [x] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- [ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- [ ] MILLIMAN CARE GUIDELINES
- [x] 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)