

I-Resolutions Inc.

An Independent Review Organization
8836 Colberg Dr.
Austin, TX 78749
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/05/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

63030 Lumbar Laminectomy, Discectomy, Foraminotomy and Partial Facetomy at L3-4 and L4-5, and 77002 Needle Localization by Xray, and 99221 Inpatient Hospitalization 1 Day

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

M.D., Board Certified Orthopedic Surgeon
Spine surgeon, practicing neurosurgeon

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-TWC Treatment Guidelines
10/21/11, 11/07/11
Letter of appeal Dr. dated 11/14/11
MRI lumbar spine dated 04/11/11
Operative report transforaminal lumbar epidural steroid injection dated 06/10/11
Clinical records Dr. D.C. dated 04/12/10
EMG/NCV study dated 04/21/11
Clinic note D.C. dated 09/12/11
Clinical records Dr. dated 09/19/11
Clinical records Dr. dated 02/25/11
Clinical records Hospital Emergency Department dated 02/27/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have sustained work related injuries on xx/xx/xx. She was struck in back by a roller. She presented to emergency department with low back pain radiating down the lower extremity. She was diagnosed with acute low back pain and provided medications Naproxen and Tramadol. She developed low back, left hip and left leg pain. On 02/25/11 she presented with complaints of low back pain and left leg numbness. She is reported to have undergone MRI of lumbar spine. She is pending EMG/NCV studies. On physical examination she had complaints of low back pain. Lumbar range of motion is mildly reduced. She has complaints of whole left leg numbness. Straight leg raise is negative. She has slightly weaker reflex on left side. MRI of lumbar spine dated 04/11/11 notes L1-2 and L5-S1 are normal. At L2-3 there is broad 2 mm disc protrusion with borderline canal stenosis. At L3-4 there is broad 1 mm disc protrusion with 3 mm left posterolateral

component and mild left neural foraminal narrowing. At L4-5 there is a broad 2-3 mm disc protrusion with mild bilateral neural foraminal narrowing. On 04/29/11 the claimant underwent EMG/NCV studies. This is reported to show evidence of bilateral S1 radiculopathy, right-sided L4 radiculopathy. The claimant underwent left L4-5 transforaminal epidural steroid injections on 06/10/11. On 09/19/11 Dr. saw the claimant. The claimant has complaints of low back pain with pain into left lower extremity. She is noted to be 5'3" and 141 lbs. Range of motion is decreased. She has 4/5 strength in biceps femoris, tibialis anterior and EHL on left. Gait was antalgic. She had difficulty with heel / toe walking. Straight leg raise was positive on left. Sensory reveals hypoesthetic region in L4 and L5 distributions. She subsequently is recommended to undergo lumbar laminectomy, discectomy and foraminotomy and partial facetectomy at L3-4 and L4-5.

Dr. reviewed the initial request. Dr. non-certified the request noting MRI findings are minimal. EMG/NCV findings do not correlate with MRI findings or physical examination, and as such, the procedure does not meet ODG guidelines.

Dr. reviewed a subsequent appeal request on 11/07/11. Dr. notes that early diagnostics by MRI and electrodiagnostics were performed. The electrodiagnostic study did not include physical examination or EMG portion of test and seemed to be telephone type report. It concluded multilevel and side nerve compression. MRI revealed L2-3 bulge and L3-4 mild left foraminal stenosis and L4-5 bulge with slight L5 compression. It is noted that Dr. examination is markedly different than Dr. examination on 08/03/11, and that Dr. interpretation of MRI is markedly different than formal radiologic interpretation and would need to be clarified prior to surgical intervention. Peer to peer was not conducted.

A letter of appeal from Dr. dated 11/14/11 was submitted for review. Dr. reported that the L3-4 disc protrusion is effacing the L4 nerve root, which is correlated by physical examination findings illustrated below. The L4-5 disc protrusion is impinging upon the L5 nerve root and correlated by physical examination as illustrated below. He notes the claimant has undergone at least 6 months of conservative treatment without substantive improvement. He subsequently recommended laminectomy, discectomy, foraminotomy, and partial facetectomy.

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

This claimant has unremitting back pain with radiculopathy not relieved by physical therapy, oral medications, and interventional procedures. She continues to have significant levels of dysfunction and continues to have objective findings of radiculopathy on examination and by electrodiagnostic studies. Based upon these submitted clinical records, the reviewer finds the requested 63030 Lumbar Laminectomy, Discectomy, Foraminotomy and Partial Facetectomy at L3-4 and L4-5, and 77002 Needle Localization by Xray, and 99221 Inpatient Hospitalization 1 Day are medically necessary.

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 KNOWLEDGBASE

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)