**SENT VIA EMAIL OR FAX ON**
**Jun/10/2011**


# Independent Resolutions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/09/2011
**IRO CASE #:**
**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
Lumbar Foramenotomy L4/5

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**
Board Certified Orthopedic Surgeon, Practicing Neurosurgeon

**REVIEW OUTCOME:**
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[ ] Upheld (Agree)
[X] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY SUMMARY**
The injured employee is a male whose date of injury is xx/xx/xx. He reported that he was lifting an axle of big rig when he heard and felt a loud pop in his left knee. Several hours later he was walking on asphalt and stepped in a hole hurting his left knee again and fell onto his left side injuring his left hip and low back as well. MRI of the left knee done on 01/06/10 revealed a complex tear of posterior horn and body of medial meniscus. The injured employee underwent left knee partial medial meniscectomy on 04/29/10. The injured employee did well following surgery. The injured employee continues to complain of low back pain radiating to left lower extremity with numbness and tingling going down the leg. The injured employee was seen for new patient consultation on 01/07/11. The injured employee has not really had much improvement with SI joint injection on left or with epidural steroid injections stating he maybe got 25% improvement which was not lasting. Physical therapy has not made him any better, and in fact seems to think it made him worse. The injured employee has noted worsening of diabetic neuropathy over the past year. The injured employee has tried course of Viagra but has not seen any improvement in erectile dysfunction. Physical examination on 01/07/11 reported the injured employee to be 6’3” tall and weighs 180 lbs. He walks slowly with wide based gait and has obvious pain with steppage on left lower extremity. Range of motion testing of lumbar spine revealed extension only to 5 degrees with severe exacerbation of pain, flexion to 45 degrees again with some exacerbation of pain not as bad as with extension. Lateral bending to either side produces severe low back pain. Manual motor testing of bilateral lower extremities revealed significant weakness of left tibialis anterior at 3-4/5, somewhat limited by pain. Left quad is approximately 4/5 again somewhat limited by pain. Left gastrocsoleus complex is 4/5, left EHL 4/5, right quad 5/5, tibialis anterior 5-/5, right EHL and gastrocsoleus 5-/5. Sensation is grossly intact to light touch in bilateral lower extremities with exception of peripheral neuropathy which is symmetric in bilateral lower extremities. Reflexes are 1+ and symmetric in bilateral lower extremities. Seated sciatic tension sign is positive on left leg with reproduction of pain shooting down left leg with reproduction of pain shooting down left leg with extension of knee. MRI dated 01/06/10 was noted to show disc desiccation and loss of disc space height at L4-5 with mild disc bulge.

There is minimal bilateral foraminal stenosis
at L4-5. There is no large central herniation. There is no foraminal stenosis at L5-S1. It was noted that MRI findings definitely were not consistent with current examination. There was no large neural compressive lesion noted on MRI. Repeat MRI dated 02/16/11 revealed L5- S1 degenerative facet joint changes bilaterally, with no significant disc protrusion or disc extrusion seen. There are no signs of central canal stenosis or neural foraminal stenosis. At L4-5 there is disc desiccation without disc space height loss. There is a 5 mm broad based posterior disc protrusion lateralizing to the right of midline containing an annular fissure deforming the right anterior aspect of thecal sac without central canal stenosis. Degenerative facet joint changes were also noted at this level. There was mild bilateral neural foraminal narrowing. Degenerative facet changes also were noted at this level. There was mild bilateral neural foraminal narrowing. At L3-4 there is a 4mm broad based posterior disc protrusion with degenerative facet changes but no central canal stenosis and mild bilateral foraminal narrowing. At L2-3 there is a 3mm annular bulge with degenerative facet joint changes but no central canal stenosis. Electrodiagnostic testing from 07/08/10 revealed findings consistent with peripheral neuropathy most likely from the injured employee's diabetes. EMG revealed findings consistent with a bilateral L5-S1 radiculopathy of mild to moderate severity.

A request for lumbar foraminotomy L4-5 was reviewed on 03/30/11 and determined to be non-certified as medically necessary. The reviewer noted that physical examination dated 02/25/11 revealed tension signs on the left sciatic nerve. There was no clear documentation of recent comprehensive clinical evaluation that would specifically correlate with the diagnosis of lumbar spine radiculopathy without straight leg raise test and progression of neurologic deficits. There was no documentation provided with regard to failure of the injured employee to respond to conservative measures such as evidence based exercise program and medications prior to proposed surgical procedure including objective response and procedure report of previous SI joint and epidural steroid injections.

An appeal request for lumbar foraminotomy at L4-5 was reviewed on 04/25/11 and determined to be non-certified. The reviewer noted per medical report dated 03/09/11 the injured employee showed persistent low back pain. Physical examination on 02/25/11 revealed tension signs on left sciatic nerve. There is still no clear documentation of recent comprehensive clinical evaluation that would specifically correlate with diagnosis of lumbar spine radiculopathy without straight leg raise test and progression of neurologic deficit. There was still no documentation provided with regard of the failure to respond to conservative treatment including evidence based exercise program and medications and including objective response and procedure report of previous sacroiliac joint and epidural steroid injections. Records indicate the injured employee had poor response to conservative treatment, but there were no therapy progress reports objectively documenting the clinical and functional response the injured employee previously rendered.

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

Based on the clinical information provided, the proposed lumbar foraminotomy L4-5 is indicated as medically necessary. The injured employee sustained injury to low back and left knee in xx/xx. The injured employee underwent left knee partial medial meniscectomy with improvement noted. He continued to complain of low back pain. The injured employee was treated conservatively with medications, physical therapy and epidural steroid injections. The records reflect that physical therapy did not make him any better and in fact seemed to have worsened his condition. The injured employee reported only about 25% relief with injections without lasting benefit. The injured employee also noted worsening of diabetic neuropathy. The injured employee was noted to demonstrate neurologic claudication. Noting objective findings on MRI with broad based disc protrusion at L4-5 lateralizing to the right, and noting the failure to respond to conservative treatment, surgical intervention is indicated as medically necessary to decompress lumbar spine at L4-5.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

**[ X ] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**[ X ] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**