INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 03/23/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC, REEXPLORATION, SINGLE INTERSPACE; LUMBA
DATES OF SERVICE FROM 02/14/2011 TO 02/16/2011

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

Texas Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Undated - Pre-Authorization Request
2. 01/13/10 - MRI Lumbar Spine
3. 05/10/10 - Clinical Note - Unspecified Provider
4. 06/08/10 - Operative Report
5. 07/26/10 - Clinical Note - M.D.
6. 09/28/10 - MRI Lumbar Spine
7. 12/17/10 - Clinical Note - M.D.
8. 02/08/11 - Clinical Note - M.D.
9. 02/15/11 - Peer Review
10. 02/26/11 - Notice of Adverse Determination
11. 02/23/11 - Utilization Review
12. 02/24/11 - Notice of Adverse Determination

13.**Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury to the low back on xx/xx/xx .

An MRI of the lumbar spine performed 01/13/10 demonstrated moderate loss of disc height and disc signal on T2 weighted images at L5-S1. There was posterior and right paracentral disc protrusion measuring up to 4 mm without spinal stenosis or neural foraminal narrowing. There was extension of disc material below the level of the disc in the epidural space.

The employee was seen for evaluation on 05/10/10. Physical examination revealed mildly reduced strength of the left lower extremity. Deep tendon reflexes were normal. Lumbar range of motion was decreased and painful. The employee was assessed with displacement of lumbar intervertebral disc without myelopathy. The employee was recommended for surgical intervention.

The employee underwent left L5-S1 minimally invasive microdiscectomy and annular repair on 06/08/10.

The employee was seen for postoperative evaluation on 07/26/10. The note stated the wound was clean, dry, and intact. The employee's examination was stable. The employee was recommended for a home physical therapy regimen.

An MRI of the lumbar spine performed 09/28/10 demonstrated status post left hemilaminectomy and discectomy at L5-S1. There was a mild asymmetric broad-based bulge of the mildly degenerative postoperative disc. There was no focal recurrent or residual disc herniation. There was mild bilateral facet arthrosis. There was mild left foraminal stenosis by bulging disc and small marginal osteophytes. The right neural foramen was normal.

The employee saw Dr. on 12/17/10 with complaints of low back pain and lower extremity radiculopathy rating 8 to 9 out of 10. Current medications included Hydrocodone and Ambien. Physical examination revealed full strength throughout. The employee ambulated with a normal gait. Lumbar flexion was to 80 degrees. There was loss of sensation noted in the left lower extremity along the L5 distribution. There was no paravertebral spasm noted. Straight leg raise was positive bilaterally. The employee was assessed with low back pain, L5-S1 herniated nucleus pulposus, and status post L5 microdiscectomy. The employee was prescribed Neurontin, Norco, and Flexeril. The employee was recommended for transforaminal epidural steroid injections.

The employee saw Dr. on 02/08/11 for surgical consultation for continued back and leg pain. The note stated the employee had failed eight months of conservative treatment since the 06/08/10 surgery. Physical examination revealed paravertebral muscle spasm with positive extensor lag. There was sciatic notch tenderness bilaterally. Lasegue's was positive bilaterally at 45 degrees. There was weakness of the gastroc-soleus on the left greater than right without atrophy. There was paresthesia in the L5 and S1

nerve root distribution. Radiographs of the pelvis demonstrated hips without degenerative joint disease and sacroiliac joints without sclerosis. Radiographs of the lumbar spine demonstrate clinical instability at L5-S1 with anterior and posterior column lack of function. Anterior column support on standing measures only 5 mm for a total loss of 10 mm, associated with posterior column dysfunction with facet subluxation, lateral recess stenosis, and foraminal stenosis. The employee was assessed with failed lumbar spine syndrome with left greater than right recurrent radiculopathy and functional spinal unit collapse with failure of conservative treatment. The employee was recommended for revision lumbar spine surgery at L5-S1 with decompression discectomy and instrumented arthrodesis with reduction of his subluxation at L5-S1.

The request for laminotomy (hemilaminectomy) with decompression of nerve roots, including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace, lumbar was denied by utilization review on 02/16/11 due to lack of no evidence of significant postoperative changes. There was no severe spondylolisthesis or motion segment instability identified by the MRI study. It was unclear to what extent the employee has exhausted conservative treatment as recommended by current evidence-based guidelines.

The request for laminotomy (hemilaminectomy) with decompression of nerve roots, including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace, lumbar was denied by utilization review on 02/24/11 as there was no evidence on MRI of recurrent or residual disc herniation at L5-S1.

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

The request for laminotomy (hemilaminectomy) with decompression of nerve roots, including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace, lumbar is not recommended as medically necessary. Based on the clinical documentation provided for review, the employee has been recommended for decompression and fusion procedures for the lumbar spine. The request as submitted is for decompression only. Given the difference between recommended procedures and requested procedures, medical necessity is not established.

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

Official Disability Guidelines, Online Version, Low Back Chapter

ODG Indications for Surgery -- Discectomy/laminectomy --
Required symptoms/findings; imaging studies; & conservative treatments below:
I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.
Findings require ONE of the following:

A. L3 nerve root compression, requiring ONE of the following:
1. Severe unilateral quadriceps weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps weakness
3. Unilateral hip/thigh/knee pain

B. L4 nerve root compression, requiring ONE of the following:
1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
3. Unilateral hip/thigh/knee/medial pain

C. L5 nerve root compression, requiring ONE of the following:
1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
2. Mild-to-moderate foot/toe/dorsiflexor weakness
3. Unilateral hip/lateral thigh/knee pain

D. S1 nerve root compression, requiring ONE of the following:
1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
3. Unilateral buttock/posterior thigh/calf pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

A. Nerve root compression (L3, L4, L5, or S1)

B. Lateral disc rupture

C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:
1. MR imaging
2. CT scanning
3. Myelography
4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following:

A. Activity modification (not bed rest) after patient education (>= 2 months)

B. Drug therapy, requiring at least ONE of the following:

1. NSAID drug therapy
2. Other analgesic therapy
3. Muscle relaxants
4. Epidural Steroid Injection (ESI)

C. Support provider referral, requiring at least ONE of the following (in order of priority):
1. Physical therapy (teach home exercise/stretching)
2. Manual therapy (chiropractor or massage therapist)
3. Psychological screening that could affect surgical outcome
4. Back school (Fisher, 2004)

For average hospital LOS after criteria are met, see Hospital length of stay (LOS).