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### Notice of Independent Review Decision

**DATE OF REVIEW:** 3-24-2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of lumbar laminectomy and microdiscectomy at L4-L5.

**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. This 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 lumbar laminectomy and microdiscectomy at L4-L5.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: MD.

These records consist of the following (duplicate records are only listed from one source):  
Records reviewed from doctor/facility included: MD orthopedic report 2-7-2011, 12-3-2010, X-ray report 12-3-2010, MDR paperwork. telephone conference 2-18-2011 and 2-28-2011,  
*Chapter 11—Microsurgical Annular Reconstruction Following Lumbar Microdiscectomy*

(conclusion), Chapter 15 Repair of the Annulus Fibrosus After Lumbar Discectomy (conclusion), Notification of Determination 2-18-2011; DC report 8-9-2010, ROM/MMT 12-3-2010; Repp DC EMG/NCV 10-26-2010; MD MRI 9-14-2010.

Records reviewed from the URA included: Notice of Determination 2-18-2011, 3-1-2011

A copy of the ODG was not provided by the Carrier/URA for this review.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

On February 7, 2011, the AP (Dr. ) indicated that the claimant has low back pain with left leg radiation, along with paresthesias in the L5 distribution. There was noted to be reduced motor strength and blunted reflexes, along with a + SLR. The diagnosis was noted to be an HNP at L4-5 with L5 radiculopathy. Treatment has included medications, PT and ESIs, as per Dr. records. A 3<sup>rd</sup> lumbar ESI was felt indicated by the AP (Dr.). A prior October 26, 2010 dated EMG was noted to reflect a left L5 radiculopathy. A prior September 14, 2010 dated MRI was noted to reflect an HNP at L4-5.

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

Without documented evidence of the actual results from the ESIs (especially the most recent) and the PT and specific medications; there is no present evidence of a trial and failure of a comprehensive non-operative treatment protocol. Therefore, applicable guidelines do not support surgical intervention at this time.

Reference: ODG-Lumbar Spine

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 ( $\geq$  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)

**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)