

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/25/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L5-S1 lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, 2 days inpatient stay

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

MD, Board Certified Orthopedic Surgeon

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

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xx. Records indicate the injured employee was removing a when he slipped and felt a sharp pain to low back. The injured employee has been treated with physical therapy, medications, and epidural steroid injections without significant improvement. MRI of the lumbar spine performed on 01/28/10 was noted to reveal L4-5 annular disc bulge flattens the thecal sac; mild bilateral foraminal narrowing was seen. At L5-S1 there is a 4 mm focal right subarticular disc herniation impinging on the right S1 nerve root sleeve, bilateral foraminal narrowing. Lumbar x-rays on 01/05/10 were noted as unremarkable. Electrodiagnostic testing performed on 04/14/10 was a normal study with no electrical evidence of lumbar radiculopathy,

mononeuropathy or polyneuropathy. The injured employee was seen in surgical consultation by Dr. on 02/08/11 with chief complaint of back pain and right leg pain. Physical examination at that time revealed positive spring test, interiliac crest line, positive sciatic notch tenderness on the right, positive extensor lag, positive flip test bilaterally, positive Lasegue's on the right at 45 degrees, contralateral positive straight leg raise on left at 75 degrees with pain from back and right lower extremity, and positive Braggard's on the right. Posterior tibial tendon jerks were absent bilaterally, and ankle jerk on right was hypoactive. There were paresthesias in the L5 and S1 nerve root distribution the right, and weakness of gastrocnemius on right without atrophy. The injured employee was referred for presurgical psychological screening on 03/03/11 at which time the injured employee was recommended to undergo three individual psychotherapy sessions pre procedure and 3 post procedure.

A request for L5-S1 lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation and inpatient stay x 2 days was reviewed by Dr. on 03/24/11. Dr. determined the request to be non-certified. Dr. noted that the injured employee has back and radicular leg complaints following injury. The medical records document a normal EMG/NCV on 04/14/10. A 01/28/10 MRI report described a right L5-S1 focal disc protrusion impinging on the right S1 nerve root with bilateral neural foraminal narrowing seen. Per discussion with Dr., the injured employee was reported to have bone on bone L5-S1 with functional instability and complete disc collapse. Dr. asked Dr. if there was any motion on flexion / extension studies, and Dr. explained there was no subluxation or angular change. Dr. noted in this case that there did not appear to be any structural instability on motion studies, and no previous surgery to lumbar spine. He therefore rendered adverse determination regarding requested surgical intervention and inpatient stay x 2 days.

A reconsideration request was reviewed by Dr. on 03/31/11. He summarized pertinent clinical information noting the injured employee complains of persisting low back pain bilaterally left worse than right with complaints of numbness on bottom of foot. The injured employee has been treated with multiple physical therapy visits, epidural steroid injections, and multiple medications. Physical examination on 01/11/11 showed positive straight leg raise in seated position on right and negative on left. Quadriceps reflexes were symmetric and equal bilaterally at 2+. Achilles reflex was 1+ on right and 2+ on left. Sensation was mildly decreased on the right S1 dermatome. Motor strength was 5/5 in all muscle groups tested except right gastrocnemius 4+/5. MRI was reported to show focal subarticular protrusion impinging on right S1 nerve root sleeve and neural foraminal stenosis by one evaluator and L5-S1 contained disc herniation with nuclear extrusion and disc desiccation by another evaluator. Examination on 02/08/11 reported positive Lasegue's on the right at 45, contralateral positive straight leg raise on left at 75 with pain from back to right lower extremity. There was absent posterior tibial tendon jerks bilaterally and hypoactive ankle jerk on right. There were paresthesias in L5 and S1 nerve root distribution on right with weakness of gastrocnemius on right without atrophy. Electrodiagnostic studies showed no electrodiagnostic evidence of lumbar radiculopathy or neuropathy. Dr. noted that based on the available medical documentation with positive imaging studies and physical examination consistent with lumbar radiculopathy, surgical intervention may be appropriate; however, the requested L5-S1 lumbar laminectomy, discectomy, arthrodesis with cages, and posterior instrumentation with 2 day inpatient stay appears to be excessive and overly aggressive. Accordingly, Dr. determined the decision to not be considered reasonable or medically necessary.

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

Based on the data reviewed, the request for L5-S1 lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, 2 days inpatient stay is not medically necessary. Injured employee is noted to have sustained an injury to the low back on xx/xx/xx. His condition was refractory to conservative care including physical therapy, medications and epidural steroid injections. MRI of the lumbar spine revealed a 4mm focal right subarticular disc herniation at L5-S1 impinging on the right S1 nerve root sleeve with bilateral foraminal narrowing. At L4-5 there is an annular disc bulge flattening the thecal sac with mild bilateral foraminal narrowing. Electrodiagnostic testing was reported as a normal

study with no electrical evidence for a lumbar radiculopathy or mononeuropathy or polyneuropathy of the lower extremities. Radiographs of the lumbar spine including flexion extension views performed 03/31/11 revealed moderate loss of vertical disc height at L3-4; mild loss of vertical disc height at L2-3 and L4-5; and moderately severe disc degeneration at L5-S1. There was mild to moderate facet joint arthrosis at L4-5 and L5-S1. Flexion extension views showed 2mm of retrolisthesis at L4-5 extension and neutral alignment in flexion. Clinical examination revealed sensory change in the S1 distribution as well as motor weakness in the right gastrocsoleus 4+/5.

Straight leg raise was positive on the right, negative on the left. As the other peer reviewers have suggested, discectomy on the right at L5-S1 with decompression of the right S1 nerve root may meet the guideline criteria. However the guidelines are not satisfied for the proposed laminectomy discectomy and arthrodesis with cages and posterior instrumentation. The reviewer finds there is no medical necessity for the procedure as requested: L5-S1 lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, 2 days inpatient stay.

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 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)