

Notice of Independent Review Decision

DATE OF REVIEW: 10/25/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

I/P Lt Laminectomy/Discectomy L4-5 Dural Graft 1 day LOS 63030 69990

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. He has been in practice since 1998 and is licensed in Texas, Oklahoma, Minnesota and South Dakota.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Upon independent review, the reviewer finds that the previous adverse determination should be overturned for Left laminectomy with discectomy L4-5 with dural graft and one-day length of stay

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 21 page fax 10/05/11 IRO request, 59 page fax received 10/06/11 URA response to disputed services including administrative and medical records. Dates of documents range between 01/31/11 and 10/05/2011

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a female with left buttock and leg pain as a result of a reported injury xx/xx/xx. She has treated with Dr. with physical therapy, epidural steroid injections, anti-inflammatory medications, and narcotic pain medications. In addition, she has had chiropractic treatment. Unfortunately, she has failed to receive any significant relief of her symptoms despite adequate nonoperative care. Request is made for laminectomy with discectomy at L4-5, left side, with dural graft

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

Upon independent review, the reviewer finds that the previous adverse determination should be overturned.

The patient has physical examination findings and diagnostic imaging findings that are consistent with lumbar disk herniation at L4-5 with impingement of the L5 nerve root. The patient's specific symptoms include buttock and leg pain on the left side with pain into the distribution of the L5 nerve root. The patient exhibits positive straight leg raise findings as well as motor weakness into the L5 nerve root distribution on the left side.

In addition, the patient has undergone a trial of nonoperative care, which has included physical therapy, epidural steroid medications, activity modification, and medication management.

As such, I feel medical necessity is exhibited for laminectomy and discectomy at the L4-5 level on the patient's left side.

There is inadequate documentation to support the use of dural graft for this procedure

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).

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)