

# Clear Resolutions Inc.

An Independent Review Organization

6800 W. Gate Blvd., #132-323

Austin, TX 78745

Phone: (512) 772-4390

Fax: (512) 519-7316

Email: resolutions.manager@cri-iro.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Sep/27/2011

**IRO CASE #:**

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

63047 Lumbar Laminectomy And Discectomy at Right L4-5 and 63048 Addtl Level and 99221 Inpatient Hospitalization 1 Day

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

MD, Board Certified Neurosurgeon

**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 claimant is a male who is reported to have sustained work related injuries to his low back on xx/xx/xx. It is reported the claimant was lifting a heavy produce barrel when he felt a pull in his low back. The claimant was subsequently seen by on 02/22/11. He is reported to have focal low back pain. On physical examination he is noted to have negative Waddell's, positive straight leg raise on right at 30 degrees, on left at 40 degrees. He is able to stand on his toes. He can heel / toe walk. Deep tendon reflexes and sensation are intact. He has paravertebral tenderness in low back. Radiographs of lumbar spine show osteoarthritis without fractures or dislocations. He is diagnosed with lumbar strain, provided work restrictions, and oral medications.

The claimant was seen on 03/01/11. Physical examination is unchanged. He was continued on work restrictions. He was subsequently recommended to participate in physical therapy. On 03/18/11 the claimant was referred for MRI of the lumbar spine, which notes asymmetric

atrophy of the right paraspinal muscle of L1-2. At L3-4 there are bilateral foraminal zone .2cm disc herniations contributing to mild bilateral neural foraminal narrowing. At L4-5 there is a broad based 3cm disc herniation touching the ventral thecal sac contributing to mild bilateral neural foraminal narrowing. At L5-S1 there is a 2cm disc herniation approaching the thecal sac there is bilateral facet arthropathy contributing to mild bilateral neural foraminal narrowing.

On 03/24/11 the claimant was referred to Dr. Claimant presents with low back pain radiating into the bilateral lower extremities. He has been on light duty and reports no improvement in his condition. On physical examination he has limited range of motion of the lumbar spine straight leg raise is reported to be positive right greater than left at 50 degrees he has no problem walking on his heels and toes however he has difficulty bending and reaching for toes. Sensation is reported to be well preserved reflexes are present and equal. Deep tendon reflexes are equal and symmetric. Dr. opines that the MRI indicates disc herniations at L3-4 L4-5 and L5-S1. Recommends that the claimant be treated conservatively he was provided Vicodin for pain.

Records indicate that Dr. provided the claimant a prescription on 04/24/11 for participation in a work hardening program. When seen in follow up on 05/31/11 he was reported to have continued low back pain with radiation to the right lower extremity. Dr. recommends that the claimant continue in the work hardening program for another four to six weeks.

On 06/03/11 the claimant was referred for EMG/NCV, which is reported to show bilateral radiculopathy at L4, L5 and S1. Records indicate that the lumbar paraspinal musculature were not evaluated. A review of this report shows abnormalities bilaterally. Claimant was again recommended to continue with physical therapy.

On 07/25/11 the claimant is reported to have severe radicular pain in the right lower extremity with no improvement. He is reported to have difficulty walking on his heels and toes ankle and knee jerk on the right side are generally hyperactive he's reported to have weakness in dorsiflexion of the big toe on the right side reduction of pin prick sensation in the right L5 distribution he has great difficulty with bending. The claimant subsequently was opined to be a candidate for surgery at with performance of lumbar laminectomy and discectomy on L4-5 on the right.

The initial review was performed on 08/03/11 by Dr. Dr. non-certified the request noting that MR imaging is showing multilevel disease without compelling evidence of acute lesion. She noted it is unclear as to how the pattern of treatment is evidenced based. She notes previous treatments have included passive therapy and TENS, individual psychotherapy, and work conditioning with subsequent surgical request. She noted that electrodiagnostic testing is of questionable validity with presumption of multiple levels of nerve impingement.

The subsequently appeal request was reviewed on 08/29/11 by Dr. Dr. notes that EMG has no validity because it does not correlate with the claimant's symptoms, MRI or physical examination. He notes the reported weakness of dorsiflexion is subjective finding and not corroborated by nerve root compression of L5 nerve root on MRI. There is no evidence of calf atrophy to correlate with reported weakness. He finds no objective evidence of L5 radiculopathy to warrant the requested surgery. He notes MRI does not provide any information establishing compression of nerve roots. As such, the requested surgery is not medically necessary.

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

This claimant sustained an injury to his low back as a result of lifting. He was initially seen by Martha Rose, NP and there were no objective findings on physical examination which would identify a lumbar radiculopathy. The claimant later underwent MRI of the lumbar spine on 03/18/11, which shows multilevel degenerative changes with small disc protrusion/herniations without evidence of compromise of any of the exiting nerve roots. The claimant subsequently came under the care of Dr. with complaints of low back pain with radiation into the right lower

extremity.

As the claimant's treatment progressed his physical examination is reported to have gotten progressively worse. He was ultimately referred for EMG/NCV of the bilateral lower extremities on 06/03/11. A previous reviewer notes that this study was not valid -- the claimant's complaints are focal to the right side and the evaluator reports findings in the bilateral L4 L5 and S1 distributions. The evaluator did not test any of the lumbar paraspinal musculature and therefore a diagnosis of radiculopathy cannot be made on the basis of this study. It would further be noted that the claimant has findings reported bilaterally yet subjectively he only has complaints involving the right lower extremity. There is a clear lack of correlation between the claimant's subjective complaints imaging studies and electrodiagnostic studies. The denials were appropriate as the claimant did not meet criteria per evidence based guidelines. The reviewer finds no medical necessity for 63047 Lumbar Laminectomy And Diskectomy at Right L4-5 and 63048 Addtl Level and 99221 Inpatient Hospitalization 1 Day.

**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)