

# US Resolutions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Oct/24/2011

**IRO CASE #:**

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

inpatient lumbar laminectomy L3-4, L4-5 and L5-S1

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

M.D., Board Certified Orthopedic Surgeon  
Board Certified Spine 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 claimant is a male whose date of injury is xx/xx/xx, when he fell at work. He complains of low back pain radiating to the lower extremities left greater than right. MRI of the lumbar spine performed 12/16/10 revealed 3-4mm posterior marginal osteophytic ridges at L3-4 and L5-S1 that mildly indent the thecal sac. At L4-5 there is a 3-4mm focal posterocentral left paracentral disc protrusion/herniation that minimally indents the thecal sac. CT myelogram on 05/19/11 revealed multilevel spondylosis and disc protrusions. At L2-3 there is mass effect upon the traversing L3 nerve roots bilaterally. At L3-4 there is narrowing of the lateral recesses with mass effect upon the L4 nerve roots bilaterally. At L4-5 there is mass effect

upon the left L4 nerve root in the neural foramen with moderate to severe foraminal stenosis. There is also asymmetric left lateral recess narrowing mass effect upon the left traversing L5 nerves. At L5-S1 there is mass effect upon the left traversing S1 nerve root. There is contact with the right S1 nerve root without significant mass effect. Electrodiagnostic testing performed on 07/20/11 reported findings of bilateral, chronic, L4-5 radiculopathies with no findings of active denervation. The claimant was treated with physical therapy, medications and epidural steroid injections times two without significant improvement. Physical examination on 08/26/11 reported gait was ataxic. There was midline tenderness in the lower lumbar spine. Motor strength was 5/5 to the lower extremities except 4/5 right gastrocnemius, bilateral EHL, and left anterior tibialis. Sensation was decreased in the right S1 dermatome and left L4, L5 dermatome. Reflexes were 2+, except right Achilles 1+. Straight leg raise was positive bilaterally. Claimant was recommended to undergo L3 through S1 laminectomy.

Dr. who recommended non-authorization of inpatient lumbar laminectomy at L3-4, L4-5 and L5-S1 performed a pre-authorization review. According to notice dated 09/13/11, Dr. noted that the claimant does not meet guidelines. There are no neurological exam abnormalities on the left yet the request is for bilateral laminectomies. There is no indication of spinal stenosis. There are no findings of L4 root involvement. All of the findings of EMG are at L5. No S1 root findings on EMG, yet the neurologic exam abnormalities are mostly S1. There are no significant motor findings as suggested above for the surgery. Therefore medical necessity of the requested procedure was not established.

Dr. who noted the documentation reviewed indicates the claimant was injured on xx/xx/xx while on top of a material pile fell and twisted his back reviewed a reconsideration request. Claimant was noted to have already undergone a previous back surgery. Initially he was noted to have pain in the neck, thoracic spine, low back pain and bilateral leg pain. Throughout the documentation it was noted that the claimant's cervical and thoracic spine pain had improved, but still complains of low back pain and left leg pain. There is not a clear description of the claimant's symptomatology. There is no objective abnormality noted. The claimant's pain generators have not yet been identified. It is noted that the claimant has an exaggerated response to superficial skin tenderness consistent with Waddell's sign. Lumbar myelogram dated 05/19/10 (SIC) reported degenerative disc disease, some foraminal stenosis and slight 2-3mm disc bulging. MRI on 12/16/10 disclosed only findings consistent with degenerative disc disease. The claimant does not meet recommendations for requested surgery. There are no neurologic exam abnormalities, no indication of spinal stenosis. There are also no significant motor findings that would support the need of the requested surgery. Therefore the previous denial was upheld.

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

This gentleman is noted to have sustained an injury secondary to fall at work on xx/xx/xx. His condition has been refractory to conservative care including physical therapy, medications, activity modification and epidural steroid injections. Imaging studies revealed neurocompressive pathology at L3-4, L4-5 and L5-S1 with mass effect on the nerve roots. Electrodiagnostic testing reported findings of bilateral chronic L4-5 radiculopathies. On examination he is noted to have progressive neurologic deficit with worsening weakness over time as well as sensory deficits. He also has depressed Achilles reflex on the right. As such, he does meet Official Disability Guidelines criteria. Therefore, the reviewer finds that inpatient lumbar laminectomy L3-4, L4-5 and L5-S1 is medically necessary.

**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)