

# Independent Resolutions Inc.

An Independent Review Organization  
835 E. Lamar Blvd. #394  
Arlington, TX 76011  
Phone: (817) 349-6420  
Fax: (817) 549-0311  
Email: rm@independentresolutions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/22/2011

**IRO CASE #:**

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

Foraminal Lumbar Laminectomy with fusion at L3/4 and L4/5

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

Neurosurgery

**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**

OD Guidelines

Utilization review notification of determination 07/21/11 recommending non-certification for foraminal lumbar laminectomy with fusion at L3-4 and L4-5

Utilization appeal review notification of determination 08/11/11 recommending non-certification for foraminal lumbar laminectomy with fusion at L3-4 and L4-5

Neurosurgical consultation and follow-up notes Dr. 05/24/11-08/26/11

CT myelogram lumbar spine 06/14/11

MRI lumbar spine 02/22/11

Progress notes Dr. 04/22/11

Office notes Dr. 04/05/11

EMG/NCV studies 04/18/11

Peer review Dr. 07/18/11

Request for preauthorization Dr. 03/15/11

Initial evaluation Dr. 3/14/11

Progress note PA-C 02/24/11

Physical therapy progress report / plan of care update 02/11/11

EKG report 06/27/11

Clinical lab report 06/15/11

**PATIENT CLINICAL HISTORY SUMMARY**

The injured employee is a male who was injured on xx/xx/xxxx when he slid on ice and fell backwards. The patient was initially treated conservatively with physical therapy, pain medications, and activity modification / light duty. MRI of lumbar spine dated 02/22/11 revealed multilevel degenerative disc and facet changes with minimal degenerative grade I

anterolisthesis of L4 in relation to L5. There is moderate central canal stenosis and mild to moderate bilateral neural foraminal stenosis at L3-4. At L4-5 there is mild central canal stenosis and mild to moderate bilateral foraminal stenosis. At L5-S1 there is evidence of posterior annular fissuring with small left paracentral foraminal disc protrusion. Electrodiagnostic testing performed 04/18/11 reported acute lumbar radiculopathy involving L5 and S1 nerve roots bilaterally. CT myelogram performed 06/14/11 reported previous laminotomy at L5-S1 with solid posterior osseous fusion and partial interbody osseous fusion. At L4-5 there is 4-5 mm grade I anterolisthesis with severe hypertrophic facet degenerative changes and small disc bulge causing mild central canal stenosis with small endplate osteophyte causing mild effacement of right lateral recess and mild bilateral neural foraminal narrowing. At L3-4 there is mild degenerative disc disease with mild left and moderate right hypertrophic facet degenerative changes, mild hypertrophy of ligamentum flavum with small disc bulge causing moderate central canal stenosis, mild effacement of left lateral recess and minimal foraminal narrowing.

A utilization review was performed on 07/21/11 and determined that request for foraminal lumbar laminectomy with fusion at L3-4 and L4-5 was non-certified as medically necessary. The reviewer noted that peer review by Dr. dated 07/19/11 indicates the injured employee's clinical findings were rendered to be chronic and not acute in nature and did not recommend surgical intervention. Furthermore, the request includes fusion surgery, and there is no psychological evaluation clearing the injured employee for surgical intervention at this time. It was noted there was no evidence that the injured employee has undergone sufficient conservative treatment. Clinic note dated 03/14/11 indicates that the injured employee has not had any injections and only one session of physical therapy. As such, the proposed surgical procedure is not certified as medically necessary.

An appeal request for foraminal lumbar laminectomy with fusion at L3-4 and L4-5 was reviewed on 08/11/11 and non-certified as medically necessary. The reviewer noted there was adverse determination on previous review. Acknowledgment of previous non-certification due to lack of documentation and failure of conservative treatment, there is now documentation that the latest medical notes are dated 07/28/11 and 07/29/11. These records do not contain clinical information regarding recent clinical assessment of injured employee that addresses the proposed service. It was noted the injured employee presents with mid and lower back pain with associated tingling over into the left leg and thigh. On examination there was marked lumbar paraspinal muscle spasm. There was flattening of the lumbosacral curve. There was decreased range of motion. There is tenderness in the interspinous ligament of L3-4, L4-5 and sacroiliac area. Straight leg raise on left and right produced back pain and muscle contraction. CT showed L3-4 multifactorial moderate central canal and mild neural foraminal stenosis. L4-5 4-5 mm grade I anterolisthesis secondary to severe facet degenerative changes and a small annular bulge caused mild central canal and mild bilateral foraminal stenosis, small endplate osteophyte mildly narrows the right lateral recess. Electrodiagnostic studies revealed bilateral L5 and S1 radiculopathy. The injured employee apparently has undergone physical therapy for back, but was unable to tolerate it. However, there is no recent documentation of at least one symptom / finding (unilateral foot/toe/dorsiflexors weakness/ atrophy or unilateral hip/thigh/knee pain) which confirms presence of radiculopathy, associated clinical findings such as loss of relevant reflexes, muscle weakness, and / or atrophy of appropriate muscle groups, loss of sensation in corresponding dermatomes, and imaging showing instability at L3-4. Therefore, medical necessity of the request has not been substantiated.

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

After reviewing the clinical data presented, medical necessity is established for foraminal lumbar laminectomy with fusion at L3-4 and L4-5. The injured employee slipped and fell on ice. He injured his head and low back. The injured employee complained of low back pain radiating into right lower extremity. MRI of lumbar spine revealed multilevel degenerative changes with minimal degenerative grade I anterolisthesis of L4 in relation to L5. At L3-4 there is moderate central canal stenosis and mild to moderate bilateral foraminal stenosis. At

L4-5 there is mild central canal stenosis and mild to moderate bilateral neural foraminal stenosis. EMG/NCV revealed evidence of acute lumbar radiculopathy involving L5 and S1 nerve roots bilaterally. CT myelogram performed on 06/14/11 revealed L3-4 multifactorial moderate central canal and mild neural foraminal stenosis. At L4-5 there is grade I anterolisthesis secondary to severe facet degenerative changes and small annular bulge cause mild central canal and mild bilateral foraminal stenosis. At L5-S1 there is laminotomy and osseous fusion. The requesting provider noted that the injured employee's diagnosis is marked mechanical low back syndrome. It was noted the proposed lumbar laminectomy including removal of bilateral laminae spinous process, discectomy at L3-4 and osteophyctectomy at L3-4 and L4-5 would create instability at L3-4 and increase instability already present at L4-5. Based on the clinical information provided, the proposed surgical procedure with foraminal lumbar laminectomy and fusion at L3-4 and L4-5 is indicated as 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)