

# P-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/02/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Laminectomy and Decompression @ L4-5

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

Orthopedic spine surgeon, practicing 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Request for IRO dated 07/20/12

Utilization review determination dated 05/30/12

Utilization review determination dated 06/19/12

EMG/NCV Study dated 09/19/11

Clinical note Dr. dated 10/06/11

Clinical note Dr. dated 11/02/11

MRI of the lumbar spine dated 11/14/11

Clinical records Dr. dated 12/06/11 to 05/23/12

Procedure report LESI dated 01/12/12

CT Myelogram lumbar spine dated 05/04/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who is reported to have sustained injuries to her back and leg as a result of a fall occurring on xx/xx/xx. Since the fall she is reported to have pain in her back and lower extremities.

Records indicate that on 09/19/11 the claimant was referred for EMG/NCV of the bilateral lower extremities which was largely normal. She is noted to receive conservative treatment consisting of oral medications and physical therapy. She was referred for MRI of the lumbar spine on 11/14/11. This study notes a focal 3mm central protrusion at the L4-5 level. This contacts the anterior thecal sac and is partially effaced. There is mild to moderate compromise of the left and right lateral recess which could result in bilateral L5 symptoms.

There is mild to moderate compromise of the neural foramina bilaterally at L5-S1 due to a 2-3mm lateralizing disc bulge primarily contacting the exiting L5 dorsal root ganglia. There is disc desiccation with 2-3mm disc bulge at the L3-4 level.

On 12/06/11 the claimant came under the care of Dr. She reports low back pain with radiation into the lower extremities. She is noted to be working light duty as a police officer. On physical examination she has decreased lumbar range of motion. Straight leg raise is reported to be positive on the left. There is decreased sensation and strength in the left EHL of a grade compared to the right. Motor and sensory exam is intact with a slight diminishing of the left S1 reflex. She subsequently was recommended to undergo a course of physical therapy. When seen in follow up on 01/12/12 she was reported to be somewhat improved. She is noted to be taking Lyrica. She is scheduled to undergo a lumbar epidural steroid injection. On 01/12/12 a left L4-5 transforaminal epidural steroid injection was performed. It was reported to have provided 70% relief for approximately three weeks. She was recommended to undergo additional injections at the L4-5 and L5-S1 levels. Post-operatively she reported improvement.

On 04/04/12, it is reported that the epidural injection has worn off and she has developed significantly increasing back pain. She was referred for CT scan of the lumbar spine. This study notes small ventral extradural defects at L4-5 and L3-4. The lumbar subarachnoid space is patent and the bilateral lumbar nerve root sleeves fill symmetrically with contrast. CT notes a 4mm broad based posterocentral protrusion at L4-5, a 4.5mm broad based right paracentral protrusion at L3-4, and a 2mm broad based posterior protrusion at the L5-S1 level. There is a 2mm retrolisthesis of L2 on L3 without superimposed protrusion. The claimant subsequently was recommended to undergo lumbar laminectomy and decompression at L4-5.

On 05/30/12 the request was reviewed by Dr. Dr. non-certified the request. A peer to peer was conducted with Dr. who reported that the claimant had a disc herniation and spinal stenosis at L4-5 with a positive EMG and that the claimant had numbness in the left L5 distribution. It is noted that CT myelogram revealed a 4mm posterior central protrusion. The central canal and foramen remain patent. There is no evidence of nerve root compression or spinal canal stenosis. The EMG is not diagnostic for a left L5 radiculopathy. He notes that there were no sharp waves or fibrillations in the L5 enervated extremity muscles. He notes that there is no documentation of significant unilateral lower extremity atrophy and therefore the request does not meet Official Disability Guidelines.

On 06/19/12 the appeal request was reviewed by Dr. Dr. non-certified the request and notes the previous denial by Dr. on 05/30/12. He notes that based on the information provided the request did not meet guidelines criteria and the request was non-certified. He reports that no additional medical records were available for review and that the previous non-certification is supported. He notes that there are no objective signs of radiculopathy on physical examination, lower extremity atrophy, or loss of relevant reflex. He notes that CT myelogram did not document any nerve root impingement. Based on the medical documentation provided, the appeal request was not supported as medically necessary.

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

The request for lumbar laminectomy and decompression at L4-5 is not supported as medically necessary and the prior utilization review determinations are upheld. The Official Disability Guidelines require that there be correlation between objective physical examination and diagnostic studies. The submitted imaging studies do not provide any evidence of neurocompressive lesions. CT myelogram notes that there is normal nerve root sleeve filling bilaterally with no evidence of nerve root impingement. Serial physical examinations do not provide objective data establishing the presence of an active lumbar radiculopathy in the appropriate distribution. There is no evidence of motor strength loss, sensory abnormality, or loss of relevant reflex to correlate with the requested surgical level. As such, the request would not meet Official Disability Guidelines and the prior utilization review determinations

are upheld.

**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)