

Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 15, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient left sided L5-S1 Hemilaminectomy and discectomy

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

MD- Board Certified Orthopaedic Surgeon who holds a Texas Medical License.

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)

Service(s) not supported by ODG

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Type of Document Received	Date(s) of Record
Request for review by IRO for the denied service(s) of L5-S1 Hemilaminectomy and discectomy	01/17/2012
Letter from M.D. from Inc.	01/13/2012
Letter from M.D. from Inc.	01/26/2012
Progress note from The Center Clinic by Dr.	01/04/2012
MRI of the lumbar spine from Imaging Center	12/08/2011

Progress note by MD from Medical Centers	11/23/2011
Accidental Injury Claim Form	
Description of injured employee's employment (DWC Form-74	
A neurosurgery consult by Dr.	12/21/2011

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a male with a work related injury on xx/xx/xx while he was lifting some heavy bags of trash and felt a sharp pain in his lower back with radiating pain down his buttocks and legs. He was seen by Dr. on xx/xx/xx who ordered an MRI of the lumbar spine and prescribed medications. He had the MRI done on 12/08/2011 that showed long-standing DDD at L5-S1 with large broad-based disc herniation. Subsequently, he was seen by Dr. who recommended left-sided L5-S1 hemilaminectomy and discectomy.

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

As I see it, the decision to operate on this patient is based on the images. The images do not correlate with the clinical findings by history and physical as reported several times by Dr., a neurosurgeon. His reports are too vague as regards to the indications for surgery. There are more studies that might make conclusions easier. These include lumbar myelogram with CT scan, EMG, Marcaine challenge to the disc, manual therapy consult for sacroiliac dysfunction, facet block to mention a few. ODG does not approve discography. I favor the presence of a neurological deficit before considering surgery.

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 stenosisDiagnostic 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 (\geq 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)