



## Notice of Independent Review Decision

**DATE OF REVIEW:** 01/04/12

**IRO CASE #:**

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

Laminectomy (Hemilaminectomy) with Decompression of Nerve Root(s), Including Partial Facetectomy, Foraminotomy and/or Excision of Herniated Intervertebral Disc, Including Open and Endoscopically Assit

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

Board Certified in Orthopedic Surgery

### **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 or not medical necessity exists for each of the health care services in dispute.

Laminectomy (Hemilaminectomy) with Decompression of Nerve Root(s), Including Partial Facetectomy, Foraminotomy and/or Excision of Herniated Intervertebral Disc, Including Open and Endoscopically Assist – UPHELD

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Encounter Notes, MedClinic, 05/15/10, 05/24/10, 06/04/10, 06/28/10
- Lumbar Spine MRI, M.D., 06/24/10
- New Patient Evaluation, Pain Consultants, 08/22/10
- Follow Up Note, Pain Consultants, 11/01/10, 12/27/10
- Evaluation, M.D., 10/27/10
- Functional Capacity Evaluation (FCE), Healthcare Systems, 04/05/11
- Evaluation, Pain Associates, 07/14/11, 07/19/11, 09/01/11
- Physical Therapy, Physical Therapy, 08/08/11, 08/09/11, 08/10/11, 08/11/11, 08/12/11
- Pre-Authorization Request, M.D., Undated
- Denial Letter, Medical Review Institute, 10/14/11, 12/01/11
- IRO, IRO, 10/27/11
- Lumbar Spine X-Rays, Imaging & Treatment Center, 11/02/11
- Subsequent Evaluation, Spine and Rehab, 11/08/11
- Denial Letters, , 12/02/11, 12/07/11, 12/12/11
- Peer Review Report, Solutions, 12/08/11
- The ODG Guidelines were not provided by the carrier or the URA.

## **PATIENT CLINICAL HISTORY (SUMMARY):**

The patient was injured while at work lifting a couch and heard a pop in his lower back. He was initially treated at MedClinic and prescribed Ibuprofen. An MRI of the lumbar spine revealed three bulging discs. He underwent therapy at Healthcare, which had helped some. He had undergone three lumbar epidural steroid injections (ESIs). Dr. was recommending back surgery. The patient's most recent medications were Soma 350 mg one three times per day, Tramadol 50 mg one three times per day, Amitriptyline 10 mg one at bedtime and Lyrica 75 mg one three times per day.

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

At this time, the medical records fail to document a focal neurological deficit corresponding to a focal level on imaging studies and/or on electrodiagnostic studies that would support the request, which pre-authorization requests list as an open-ended request with no specific level documented. Peer Review reports showed appeal requests for an L3-S1 laminectomy/discectomy and fusion, but even with a specific level documented, at this time the medical records did not adequately document focal neurological dysfunction consistently found on physical examination amongst multiple physicians that would support the requested procedure in line with the Official Disability Guidelines criteria. The ODG criteria does indicate that for laminectomy and discectomy there be subjective and objective findings of a focal neurological deficit corresponding with appropriate

imaging studies, and at this time the medical records fail to document such information. Therefore, the requested surgery is not recommended.

**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)
- AMA GUIDES 5<sup>TH</sup> EDITION