MedHealth Review, Inc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax 972-775-6056

Notice of Independent Review Decision

DATE OF REVIEW: 3/7/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of a laminotomy with decompression nerve root an (63030) and fluoroscopic guidance needle pl (77002)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a laminotomy with decompression nerve root an (63030) and fluoroscopic guidance needle pl (77002)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed from 2/22/12 summary letter for IRO, 12/29/11 CT of lumbar spine, 12/29/11 myelogram lumbar spine report, L spine com + flex/ext radiographic report of 12/29/11, undated preauth request by 11/18/11 report by 10/13/10 operative report, 11/26/10 discharge summary from PT, and 12/28/10 to 2/7/11 evals by PT.

4/30/10 lumbar MRI report, 11/14/11 L spine com+ flex extension radiographic report, 8/9/10 operative report, 11/28/11 denial letter, 12/14/11 denial letter, and 1/23/12 office note by

10/24/11 office notes by 1/17/12 PPE report, 8/3/10 clinical interview by and 12/15/10 lumbar myelogram script.

IMO: 12/15/11 letter of reconsideration by and a patient info sheet.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant was injured when he had a tree limb fall onto him on xx/xx/xx. The 2/22/12 dated AP summation letter was reviewed. The AP's patient has persistent low back pain, sciatica and paresthesias in the left leg. Exam findings revealed a positive left straight leg raise, decreased S1 associated sensation, along with a weak left gastrocnemius and weak Achilles reflex. The 12/29/11 dated CT-myelogram was noted to reveal a left L5-S1 disc osteophyte complex with nerve root abutment. The AP's impression was back pain with radiculopathy. The 11/18/11 dated consultation discussed an indication for extensive decompression at L5-S1. Prior records included PT notes and ESI records, which were reviewed. The 1/1712 dated Functional Capacity evaluation revealed light occupational capabilities. Denial letters noted the mechanism of injury and the history of kyphoplasty's post injury on 8/5/10, at T4 and T10. The patient was status post hip debridement in June of 2011. The 4/30/10 dated lumbar MRI revealed multiple level degenerative changes and disc bulges, along with a central disc protrusion. Electrical studies dated 11/30/10 were reportedly normal. The denial letters further noted that the gastrocnemius was only minimally weak and that there was no peroneal weakness (which would be typically affected with nerve root impingement at L5-S1.) The 12/5/11 dated appeal letter discussed the clinical and radiographic findings of lumbar radiculopathy associated with L5-S1 HNP.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
The patient has both subjective an objective findings compatible with the imaging studies. The diagnosis of disc-osteophyte complex/radiculopathy at L5-S1 is supported by the motor, sensory and reflex changes that correlate with the MRI and CT-myelogram studies. Reasonable non-operative treatment of medications, injection and PT have been tried and failed. ODG criteria have been met and the requested procedures are reasonable and medically necessary at this time.

Summary: 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 stenosis

Diagnostic 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 (>= 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

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)**