



## IMED, INC.

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### Notice of Independent Review Decision

**DATE OF REVIEW:** 5/22/2012

**IRO CASE #:**

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

Appeal Transforaminal diskectomy L3-4 Left 63056 77003

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

Board Certified Orthopedic Spine Surgeon

**REVIEW OUTCOME:**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Overturned (Disagree)

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.

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

Physical therapy note dated 01/15/2012, clinical notes dated 01/16/2012 and 01/19/2012 from x-ray of the orbits dated 02/02/2012, MRI of the thoracic and lumbar spine dated 02/02/2012, physical therapy progress note dated 02/06/2012, clinical notes dated 02/06/2012, 03/14/2012, and 04/16/2012 from procedure report dated 03/01/2012, prior reviews dated 03/28/2012 and 04/20/2012, coversheet, and working documents.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male, who reported an injury on xx/xx/xx. Physical therapy evaluation dated 01/15/2012 reported the patient was injured. The patient complained of low thoracic and low back pain with occasional pain in the left posterior thigh. The clinical note from dated 01/16/2012 reported the patient had

pain in the mid-to-lower back region with radiation into the left calf intermittently. The patient was noted to be taking hydrocodone and Flexeril. The physical exam revealed 5/5 motor strength, sensation intact, positive bilateral straight leg raise, and tenderness to palpation. The MRI of the lumbar spine dated 02/02/2012 read by revealed findings of a disc bulge at L3-4 with a left foraminal extraforaminal 6 mm extrusion compressing the left L3 nerve root, causing severe left neural foraminal stenosis. The patient also had a disc bulge with 2 mm left foraminal protrusion at L5-S1 without stenosis and disc bulge at L4-5 with mild bilateral foraminal stenosis. The MRI of the thoracic spine dated 02/02/2012 read by revealed a 1 to 2 mm syrinx of the thoracic cord likely benign or idiopathic. The physical therapy progress note dated 02/06/2012 reported the patient had completed 6 sessions. The clinical note from dated 02/06/2012 reported the patient complained of 9/10 back pain with radiation into the left lower extremity. The patient reported minimal relief with 8 sessions of physical therapy. The physical exam revealed antalgic gait, positive straight leg raise on the left, and decreased sensation along the medial, anterior, and lateral thigh with 4/5 weakness on the left. The procedure report dated 03/01/2012 reported the patient underwent a transforaminal epidural steroid injection at left L3-4. The clinical note dated 03/14/2012 from reported the patient had 60% to 70% immediate relief following the injection. The patient complained of 8-9/10 pain. The patient was recommended for lumbar discectomy. Prior review by on 03/28/2012 reported the request for surgery was denied due to lack of conservative care and psychological report. Follow up with on 04/16/2012 reported the patient complained of 8/10 low back pain with radiation to the left lower extremity. The physical exam revealed continued antalgic gait, positive left straight leg raise, diminished left patella reflex, decreased sensation along the anterior, lateral thigh, and 4/5 motor weakness on the left. The patient was noted to have minimal response with physical therapy and was recommended for surgical intervention. Prior review by on 04/20/2012 reported the request for surgery was denied due to lack of conservative therapy.

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

The request for transforaminal discectomy at L3-4 on the left is certified. The documentation submitted for review indicates the patient has had persistent low back pain with radiation to the left lower extremity despite conservative care to include: medication management, 8 sessions of physical therapy, and epidural steroid injection. The MRI studies submitted for review indicate the patient had a 6 mm disc bulge at L3-4 compressing the left L3 nerve root with severe left neural foraminal stenosis. The patient had positive subjective and objective clinical findings consistent with lumbar radiculopathy corroborated by imaging evidence. Official Disability Guidelines indicate that patients should be unresponsive after conservative care to include medication management, epidural steroid injection, or physical therapy. The patient has been unresponsive

to all 3 treatment modalities. A psychological screening is not required by Official Disability Guidelines for a lumbar decompression surgery. Given the positive subjective and objective clinical findings with failure of conservative care, the prior denials are overturned, and the request is certified at this time.

## **IRO REVIEWER REPORT TEMPLATE -WC**

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### **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)

#### REFERENCES:

Official Disability Guidelines, Low Back Chapter, Online Edition.

#### ODG Indications for Surgery<sup>TM</sup> -- 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. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. ([Andersson, 2000](#)) 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 ( $\geq 2$  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