

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Oct/02/2012

**IRO CASE #:**

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

Laminectomy L4-5

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

M.D., Board Certified Orthopedic Surgeon  
Spine surgeon, practicing neurosurgery

**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.** The reviewer finds medical necessity is not established for the proposed Laminectomy L4-5.

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

ODG - Official Disability Guidelines & Treatment Guidelines  
Notification of determination 07/30/12  
Notification of determination 08/15/12  
Office notes 01/26/00-07/05/12  
MRI lumbar spine 11/02/11, 06/21/07, 09/23/05  
Operative report 11/22/06  
Office notes 02/24/04-03/07/06  
Carrier submission response to IRO 09/17/12  
Procedure reports lumbar transforaminal epidural steroid injection with percutaneous lysis of adhesions 05/04/04 and 05/18/04  
Designated doctor's evaluation 01/17/05  
Internal medicine consultation/ECG 11/01/06  
Clinical lab results 11/01/06  
Cardiology stress test report 11/09/06  
Initial evaluation and progress notes 01/24/07-04/04/07  
Required medical examination 11/14/07  
Appeal letter 09/19/12  
MRI cervical spine 03/07/97  
Progress notes 06/28/99-10/28/99  
Physical therapy assessment and progress notes 07/13/99-05/18/01  
MRI lumbar spine 11/17/99, 11/07/00  
Procedure notes lumbar epidural steroid injection 05/26/00 and 06/15/00  
Functional capacity evaluation 09/11/00  
Required medical examination 09/22/00

Office notes 01/11/01  
Operative report 01/17/01  
Procedure report transforaminal epidural steroid injection 05/09/01  
Chest x-ray 07/05/01  
CT scan paranasal sinuses 08/06/01  
SOAP note 10/18/01  
Extended duration of injury and necessity of medications evaluation 04/29/02  
Daily treatment notes 08/06/02-09/27/02  
Medical records / peer review 11/27/02, 02/20/03 and 03/28/04  
Peer review report 12/13/02

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female injured on xx/xx/xx. She was helping to lift when she experienced onset of low back pain radiating into right buttock and leg. After failing to improve with conservative treatment, the claimant underwent L5-S1 right hemilaminotomy, medial facetectomy with S1 nerve root foraminotomy, and microendoscopic L5-S1 discectomy performed on 01/17/01. She participated in post-operative physical therapy. Other treatment included transforaminal epidural steroid injections with percutaneous lysis of epidural adhesions using Wydase. The claimant had further surgical intervention on 11/22/06 with redo L4-5 micro endoscopic hemilaminotomy, medial facetectomy and L4-5 disc space exploration/decompression. MRI of the lumbar spine on 06/21/07 revealed post-operative changes of right-sided laminectomy L4-5. There was enhancing scar tissue within the epidural space extending into the right-sided neural foramen encasing the right L4 nerve root. Disc bulge combining with grade 1, 3mm spondylolisthesis at L4-5 to cause moderate to severe stenosis of the spinal canal, and moderate right-sided neural foraminal stenosis. There is a disc bulge asymmetric to the right at L5-S1 leading to moderate right sided neural foraminal stenosis. She continued to have right sided back and hip pain, lateral leg paresthesias. She was prescribed medications, and instructed to continue with a home exercise program. On 07/05/12 the claimant was noted to be having some increased right hip pain and sharp stabbing pains. Records state that she has had two or three near falls over the last several weeks. Physical examination shows right lumbosacral tenderness and right sciatic notch tenderness. She has 4+/5+ right EHL dorsiflexion. She has right-sided straight leg raise to 30 degrees. She has a poor heel walk. She has decreased L4-5 sensation. Surgical decompression at the L4-5 level has been recommended by the provider and denied twice by the insurance company. A request for laminectomy L4-5 was non-certified as medically necessary per utilization review dated 07/30/12, noting that based on the clinical documentation provided it appears the last round of physical therapy the claimant had was in 2007. There also was no indication that the claimant recently underwent epidural steroid injections or efficacy of injections. It also was unclear based on documentation of recent medications if the claimant has utilized or efficacy in terms of reducing her symptoms. An appeal request for laminectomy L4-5 was non-certified as medically necessary per utilization review dated 08/15/12 noting that previous denial was based on lack of documentation to indicate recent conservative treatments. There does not appear to be any additional information provided that would result in an overturn of the previous non-certification. The guidelines require diagnostic imaging to report nerve root compression. There is no nerve root compression reported in the last MRI of the lumbar spine. There is no documentation of recent conservative treatment of activity modification, non-steroidal anti-inflammatory medications, muscle relaxants, steroid injections, physical therapy, which is indicated by the guidelines. The guidelines will support a psychological screening that could affect surgical outcome in a claimant who has had two previous back surgeries.

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

This is an injury that occurred in 1999. The claimant sustained a lifting injury to her low back. She is status post lumbar laminectomy on the right at L5-S1 done 01/17/01. The claimant reportedly had re-do surgery at the L5-S1 level on 11/22/06; however, the operative report indicates that this surgery was at the L4-5 level. The claimant continues to complain of low back pain and right leg pain. MRI of the lumbar spine on 11/02/11 revealed multilevel degenerative changes most notably at L4-5 and L5-S1 where there is moderate to severe

right foraminal narrowing and nerve root contact at the exiting and transiting nerve roots. On examination the claimant was noted to have 4+/5+ EHL dorsiflexor, with straight leg raise to 30 degrees on the right. She had poor heel walk and decreased L4-5 sensation.

According to notes dated 07/05/12, the claimant needs surgical decompression at L4-5, which states is directly and causally related to her work related injury and L5-S1 fusion with adjacent level development; however, there is no objective evidence that the claimant has had a fusion procedure at any level of the lumbar spine. The documentation provided notes that the claimant had extensive conservative care prior to and after surgical intervention, but it does not appear the claimant has had any recent conservative care including activity modification, NSAIDs, epidural steroid injections or physical therapy. The reviewer finds that medical necessity is not established for the proposed Laminectomy L4-5.

**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)