



MedHealth Review, Inc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 12/9/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a lumbar laminectomy at L3/4, L4/5, and L5/S1.

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 lumbar laminectomy at L3/4, L4/5, and L5/S1.

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: office notes 9/20/13 to 11/20/13, and 8/28/13 report.

10/17/13 denial letter, undated surgery authorization request, 11/1/13 denial letter, 6/27/13 electrodiagnostic report, 6/21/13 cervical MRI report with addendum of 6/26/13, and 6/21/13 lumbar MRI report.

7/30/13 to 11/7/13 DWC 73 forms, daily progress notes 5/30/13 to 10/8/13 (unknown party), 10/3/13 to 11/7/13 office notes by MD, 6/26/13 to 10/8/13 office notes by DC, 7/9/13 to 10/3/13 reports by MD, 9/17/13 anesthesia record from Surgery Center, 4/30/13 to 9/30/13 office reports by MD, 9/17/13 operative reports, 9/4/13 operative report, 8/14/13 diagnostic interpretation by Dr., 8/28/13 approval letter, 7/24/13 operative reports, 8/5/13 injury rehab clinic Letter of Medical Necessity, 5/25/13 hospital notes, 7/16/13 Ortho face sheet, 12/4/12 lumbar MRI report, 2/28/07 lumbar MRI report, 5/15/13 peer to peer review report by PAC, 8/16/07 report, 12/15/06 report by DC, 11/14/06 DWC69 and report by MD, 10/30/06 DWC 69 report by DC, 5/31/06 RME report by MD, 5/9/07 to 6/20/07 reports by MD, 2/9/06 lumbar MRI report, and 3/9/06 report by MD.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The xx year old reported having a workplace-associated injury sustained in xx/xxxx. The injury was described as being a sprain-strain of the lumbar spine. The injury was reportedly superimposed upon pre-existing and ongoing congenital spinal stenosis. A 6-21-13 dated lumbar spine MRI revealed multilevel degenerative changes including stenosis. 6-27-13 dated electrical studies revealed evidence of a mild left L5 radiculopathy. As of 10-14-13, the neurological exam was noted to be unremarkable despite the ongoing and chronic low back pain with radiation into the lower extremities, inclusive of paresthesias. Nocturnal sleep incontinence has also been documented x 2. Prior treatments have been reported to include medications, ESI's and therapy. Neurogenic claudication and overall symptom and leg strength worsening was discussed on 11-25-13, along with 4/5 lower extremity strength. Denial letters discussed the lack of clinical exam abnormalities correlating with requests for multi-level lumbar laminectomies. Also discussed was the lack of detailed and recent non-operative treatments and a psychosocial screen.

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

The claimant has multilevel symptomatic spinal stenosis. (The condition is well known to not necessarily reveal objective radiculopathy on clinical examination). The claimant does have severe spinal stenosis on imaging that also correlates with the severe symptoms and electrical findings. The claimant has failed reasonable and comprehensive non-operative treatment trials. The claimant has no evidence of any abnormal psychological issues and has a worsening condition of the neurologic status. Clinical guidelines support the decompression procedures as requested. Therefore, it is found to be medically necessary based upon the guidelines and records provided.

Reference: ODG Low Back Chapter
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 (\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)