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Notice of Independent Review Decision

**Date notice sent to all parties:** 04/23/13

**IRO CASE #:**

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

Lumbar microdiscectomy at L4-L5 and L5-S1

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

Board Certified in Orthopedic Surgery  
Fellowship Trained in Spinal 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)

Lumbar microdiscectomy at L4-L5 and L5-S1 - Upheld

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

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

Lumbar MRI dated 11/04/10 and interpreted.  
FCEs dated 07/26/11 and 03/06/12  
Emergency room record dated 11/09/11  
Report dated 11/11/11

Report dated 02/17/12  
Designated Doctor Evaluations dated 02/23/12, 08/15/12, and 02/13/13  
DWC-69 forms dated 02/23/12, 01/07/13, and 02/13/13  
EMG/NCV study dated 03/01/12 and interpreted.  
DWC-73 form dated 03/14/12  
Reports dated 03/30/12, 04/19/12, 05/02/12, 06/01/12, 06/22/12, 06/27/12, 07/10/12, 07/27/12, and 08/28/12  
Report dated 06/22/12  
Reports dated 09/27/12, 10/18/12, 11/01/12, 01/07/13, 01/16/13, and 02/11/13  
Operative report dated 10/18/12  
Manual Muscle Strength testing dated 11/01/12 and 01/07/13  
RME dated 01/09/13  
Letters From attorney, dated 01/16/13 and 02/04/13  
Surgery reservation sheet dated 02/01/13  
Notifications of Adverse Determination from IMO dated 02/07/13 and 03/18/13  
The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

A lumbar MRI dated 11/04/10 revealed a very large, mainly right sided, central disc herniations at L4-L5 and L5-S1. No other definite findings were noted. An FCE dated 07/26/11 revealed the patient was functioning at the physical demand level of his previous employment and it was felt he could return to work. On 11/11/11, noted the patient was status post C4-C7 anterior cervical fusion and had lumbar disc displacement at L4-L5 and L5-S1. This report was in regard to the cervical spine. A recent CT scan showed a solidly healed cervical fusion. It was noted the sagittal plane alignment of the lumbar spine was severely stooped, which might be causing his ongoing neck pain. An updated lumbar MRI was recommended. An EMG/NCV study dated 03/01/12 revealed evidence of a subacute right L5 radiculopathy with denervation. There was borderline decreased amplitude of the bilateral sural nerve responses that could be secondary to an early sensory peripheral neuropathy. In an FCE dated 03/01/12, the patient functioned in the sedentary physical demand level. On 03/30/12, examined the patient. He had persistent low back pain

which referred to the right L3 dermatomes. Lumbar back flexion at T10 to L2 equaled 1/10. He had muscle spasms in the same area and had right SI joint tenderness. The right patellar reflex was 0 and there was weakness of the peroneal muscle in that he could not stand on his toes. An EMG/NCV study and CT scan of the lumbar spine was recommended. On 06/01/12, the patient stated he had radiated back pain to his legs and sometimes his legs would go numb in the L3, L4, and L5 dermatomes. Pinprick examination of both legs revealed the bilateral L3, L4, L5, and S1 dermatomes were abnormally dull bilaterally with the exception of the right L5, which was normal. A lumbar belt, pillow, and physical therapy were continued. On 06/22/12, examined the patient and felt he had sustained an on-the-job injury to the lumbar spine. He felt he was a candidate for a laminectomy, discectomy, and foraminotomy at L4-L5 and L5-S1. On 08/28/12, referred the patient to a surgeon. He remained off work. examined the patient on 09/27/12. He had severe lumbar tenderness and range of motion was decreased. His knee flexors, extensors, and EHLs were decreased and he had bilateral L5 paresthesias. The impression was disc herniations at L4-L5 and L5-S1 with L5 radiculopathy. A lumbar ESI was recommended and performed on 10/18/12. On 11/01/12, reexamined the patient and he had 50 to 60% relief following the ESI, but he still had lower extremity weakness, numbness, and tingling, but they had improved since the ESI. Home exercises were recommended and Mobic was prescribed. On 01/07/13, the patient informed that he had attended post injection therapy, but had temporary relief following the ESI. His examination was essentially unchanged. Lumbar laminectomy with foraminotomy was recommended. On 01/16/13, addressed a letter which stated the patient's current condition and in January 2012, he would not have been able to work. On 02/07/13, on behalf of, provided an adverse determination for the requested lumbar microdiscectomy at L4-L5 and L5-S1. provided a response to non-authorization on 02/11/13. On 02/13/13, noted the patient had reached statutory MMI on 10/24/12, but felt he had not improved in his lumbar and radicular pain since the original injury. Surgical treatment at L4-L5 and L5-S1 was felt to be beneficial. He was assigned a 10% whole person impairment rating. He felt the patient met all the indications of the ODG to proceed with surgical intervention at that time. On 03/18/13, also on behalf of, provided another adverse determination for the requested lumbar microdiscectomy at L4-L5 and L5-S1.

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

The patient's original injury was a lifting injury in xx/xx. The physical examination of this patient has changed dramatically, often differing in short amounts of time between different examiners. There has been no clear description of radiculopathy. The examination documented is significantly different than the examinations by other providers. The subacute L5 radiculopathy does not correlate with the patient's symptoms. In the absence of objective weakness, numbness, or paresthetic sensation, it is unlikely that a lumbar discectomy at L4-

L5 or L5-S1 would change this patient's chronic symptoms. Furthermore, the patient does not meet the ODG criteria for surgical intervention. Therefore, the requested lumbar microdiscectomy at L4-L5 and L5-S1 is not appropriate and the previous adverse determinations should be upheld at this time.

**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)