

**IRO REVIEWER REPORT TEMPLATE -WC**

---

**ReviewTex. Inc.**  
**1818 Mountjoy Drive**  
**San Antonio, TX 78232**  
(phone) 210-598-9381 (fax) 210-598-9382  
reviewtex@hotmail.com

**Notice of Independent Review Decision**

**Date notice sent to all parties:**

February 14, 2013

**IRO CASE #:**

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

Reconsideration of Forte's NON-AUTHORIZATION of Inpatient (IP) lumbar laminectomy, discectomy, foraminotomy and partial facetectomy at L5-S1 with one (1) day inpatient stay.

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

Board Certified Neurosurgeon

**REVIEW OUTCOME:**

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

Upheld (Agree)

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:**

1. Office visit/progress notes Dr. PA-C 01/03/12-07/25/12
2. Physical therapy progress notes 01/09/12-04/23/12
3. Notice of utilization review findings 01/24/12
4. MRI lumbar spine 01/24/12
5. MRI cervical spine 02/09/12
6. MRI thoracic spine 02/17/12
7. Notice of disputed issues and refusal to pay benefits 02/29/12
8. Peer review Dr. 02/29/12
9. Notice of utilization review findings 04/13/12
10. Neurosurgery consultation Dr. 04/16/12 and 08/13/12
11. Office notes Dr. 05/08/12-07/02/12
12. Notice of utilization review findings 05/16/12
13. Designated doctor evaluation Dr. 06/07/12
14. Notice of utilization review findings 06/08/12
15. Peer review Dr. 08/13/12
16. EMG/NCV 08/29/12
17. History and physical and follow up notes Dr. 09/08/12-12/05/12
18. MRI thoracic spine 09/18/12
19. Initial rehab evaluation, DC 09/10/12 and 11/05/12
20. Drug screen/toxicology report 11/07/12 and 12/07/12
21. Functional capacity evaluation 11/14/12
22. Report of maximum medical improvement/impairment DC 01/08/13
23. Notice of utilization review findings 11/14/12
24. Notice of utilization review findings 11/27/12

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

The claimant is a female whose date of injury was xx/xx/xx. Records indicated that she was standing on a chair cleaning cabinets and reached up to wipe the shelf and developed onset of low back pain radiating to the right lower extremity. The claimant was treated conservatively including physical therapy and medications without significant improvement and records indicated that she was recommended to undergo epidural steroid injection therapy, but the request for lumbar epidural steroid injection was not approved. The claimant was determined to have reached maximum medical improvement with 0% whole person impairment per designated doctor evaluation dated 06/07/12. The claimant was recommended to undergo surgical intervention with lumbar laminectomy, discectomy, foraminotomy, and partial facetectomy at L5-S1 with one day inpatient stay.

The request for inpatient surgery at L5-S1 was non-authorized on 11/14/12 noting that the claimant did not have a significant injury consistent with producing a disc

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

problem according to literature. Her MRI showed no disc herniation or disc bulge at L5-S1. She had quad weakness (L4) and she can walk on her toes, although she limps. Therefore, medical necessity was not established as the claimant did not meet guidelines.

A reconsideration request was reviewed on 11/27/12 and the proposed inpatient lumbar laminectomy, discectomy, foraminotomy, and partial facetectomy at L5-S1 with one day inpatient stay were non-authorized and the original denial was upheld. It was determined that the claimant did not have any reasonable medical need for the requested surgery and the request could not be authorized.

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

The claimant sustained an injury to the low back on xx/xx/xx while cleaning shelves and developed low back pain radiating to the right lower extremity. Her condition was refractory to conservative care including physical therapy and medications. MRI of the lumbar spine revealed multilevel spondylosis and facet arthropathy with borderline central canal stenosis at L2-3 and L4-5. Multilevel neural foraminal narrowing was noted most pronounced on the right at L4-5 and L5-S1. Electrodiagnostic testing on 08/29/12 reported no abnormal findings in relation to plexopathy, neuropathy, and/or radiculopathy. Examination on 08/13/12 reported 4/5 strength in the gastrocnemius on the right, otherwise 5/5 throughout. Deep tendon reflexes were +1 in the right ankle jerk, otherwise +2 throughout and symmetrical. Gait was antalgic. The claimant had difficulty with toe walking, less difficulty with heel walking, and no difficulty with tandem walk. Straight leg raise was positive at 45 degrees on the right and negative on the left. There was decreased sensation in the L5 and S1 distribution on the right, otherwise intact. However, the designated doctor reported the claimant had no objective sensory deficit and no objective motor deficit of the lumbar spine or lower extremities. Based on the clinical data provided, it is the opinion of this reviewer that medical necessity has not been established. The claimant has comorbid conditions including diabetes and obesity. She has no objective findings of lumbar disc herniation with nerve root compression on imaging studies, with a normal EMG/NCV study. She does have evidence of facet arthropathy of the lumbar spine, but there is no indication that there has been any attempt to determine if there is facet mediated pain. Therefore, all pain generators have not been identified. As such, the requested surgical procedure does not meet ODG criteria.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**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. 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:

## IRO REVIEWER REPORT TEMPLATE -WC

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).