

**IRO REVIEWER REPORT TEMPLATE -WC**

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Notice of Independent Review Decision

**Date notice sent to all parties: 12/31/12**

**IRO CASE #:**

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

CPT 63047, 22114, 20926, 63048, Lumbar Laminectomy L4, L5, and S1

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

**Texas Licensed Neurosurgeon**

**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 of the health care services in dispute.

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

1. Reconsideration determination letter of 12/4/12
2. Notice of Adverse Determination letter dated 11/5/12
3. Office notes dated 11/16/12, 10/26/12,
4. MRI lumbar spine, 3/28/12
5. 1/18/11 MRI study of lumbar spine
6. notes dated: 2/13/12, 12/30/10,
7. 9/21/11 operative report
8. 11/1/11 note from Dr. XXXX

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

The patient injured herself in a fall. No further details of how she fell or how she landed were available to me. The patient did have an MRI scan that was on 01/18/2012 before she had a surgery for an L5-S1 discectomy and another MRI scan on 03/28/2012, which was after her procedure. The patient is complaining of severe back pain radiating into her right leg and calf. The patient states that the pain is constant, moderate in intensity and according to the clinical exam, is associated with weakness, 4/5 on the right quadriceps femoris and 4/5 on the right psoas muscle. There is no documentation of sensory loss and there is documentation showing no change in normal reflexes throughout. There is no documentation of any atrophy. The patient does have an EMG showing a right S1 radiculopathy or a mention of an EMG on a clinic note dated 02/13/2012. The patient's MRI scan of 03/28/2012 shows no significant findings indicating nerve root compression, lateral disruption, or lateral recess stenosis. The patient has undergone conservative therapy to include analgesic therapy, muscle relaxants, lumbar epidural steroid injections, and 20 sessions of physical therapy. There is no documentation of activity modification, no documentation of patient education, no documentation of psychological screening, and no documentation of back school.

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

According to the ODG guidelines for the requested surgery of a laminectomy, the patient has to have one of the following, L3 nerve root compression, severe unilateral quadriceps weakness or mild atrophy, mild to moderate unilateral quadriceps weakness, or unilateral hip, thigh or knee pain. For L4 nerve root compression one of the following, severe unilateral quadriceps or anterior tibialis weakness or mild atrophy, mild to moderate unilateral quadriceps, anterior tibialis weakness or unilateral hip, thigh, knee or medial pain. For L5 nerve root compression one of the following,

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severe unilateral foot, toe, dorsiflexor weakness or atrophy, mild to moderate foot, toe, dorsiflexor weakness or unilateral hip, lateral thigh or knee pain, and for S1 nerve root compression one of the following, severe unilateral foot, toe, plantar flexor, hamstring weakness or atrophy, moderate unilateral foot, toe, plantar flexor or hamstring weakness or unilateral buttock, posterior thigh, or calf pain. EMGs are optional to obtain an equivocal evidence of radiculopathy, but not necessary; radiculopathy is already clinically obvious.

### CRITERIA:

1. The patient does have mild weakness of the quadriceps femoris and mild weakness of the psoas muscle.
2. No evidence of any radiographic findings on any of these required criteria.
3. Conservative therapy, all of the following must be met:
  - A. Activity modification not to include bed rest after patient education of greater than two months.

There is no note in the records anywhere of any activity modification or any patient education given.

B. Drug therapy to include NSAID therapy or other analgesic therapy or muscle relaxants or epidural steroid injection.

She has had other analgesic therapy, muscle relaxants, and epidural steroid injections. She has not had any activity modification or education as mentioned.

C. Must have one of the following, physical therapy, manual therapy, psychosocial screening, and back school.

She has had 20 sessions of physical therapy. Given the lack of radiographic findings and the lack of evidence of activity modification, this patient's request of surgery does not meet medical criteria by ODG guidelines.

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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)