

Independent Reviewers of Texas
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Notice of Independent Review Decision

DATE REPORT WAS SENT TO ALL

PARTIES: 05/06/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Laminectomy, foraminotomy, and decompression of the nerve root at left L3-4 between 02/24/2014 and 04/25/2014.

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury to his low back and his neck on xx/xx/xx. The mechanism of injury was not stated. The patient is noted to have undergone multiple surgeries including 2 cervical spine fusions, a surgery to his left leg with a vascular stents, and 2 back surgeries, the last being a lumbar

laminectomy and fusion at L4-5 on an unstated date. A clinical note dated 09/11/2013 reported the patient had done well initially following his previous surgery but reported chronic back pain and pain at his SI joints and pain above where he had surgery that had worsened over the last year or 2. The patient is reported to be at a point where he had very poor mobility, having lost the use of his legs. He reported chronic left foot pain stemming from an injury to the left foot and a surgery by a podiatrist on that foot which was unsuccessful in the patient's words, but he reported his pain was in his leg with walking or activities. He noted he could walk about 1 to 2 blocks before he had to stop because of tingling pain and cramping in his legs and noted both legs were equal in that respect. The patient was diagnosed with vascular claudication and is noted to have undergone iliac stents bilaterally which the patient reported did not help him as he thought it would as far as his claudication type symptoms. The patient is reported to have tried exercises and to have undergone quite a bit of pain management for his low back without real relief. On physical exam, the patient is noted to have his left foot immobilized in a makeshift brace. He had pitting edema of his left leg and it was noted to be red and swollen. On physical exam, he was reported to have possibly some left foot weakness but it was difficult to be certain because it was not sensitive. The rest of his strength exam was more or less normal and he did not have any functional loss of strength. On gait examination, he was noted to favor his left foot which was immobilized foot but he was reported to be able to get up and down fairly well. On examination of his back, he had well healed midline incision, a little bit of tenderness bilaterally over his SI joints, and a little bit of tenderness above his incision at about the L3-4 segment. Sensory examination noted hypersensitivity of his left foot to touch but patchy hypesthesia in other areas of the legs. Reflexes were noted to be absent or minimal. A recent CT of the cervical spine was reported to show a 2 level fusion that seemed like it had taken. An MRI was performed on an unstated date and was reported to show an interbody fusion at L4-5 and L5-S1 which appeared solid; there was a wide decompression of the canal and foramina at both levels; at L4-5, he had a disc bulge as well as facet hypertrophy and facet diastasis on both sides, right worse than left, consistent with facet arthropathy. On 01/16/2014, the patient was seen for review and evaluation of MRI and x-rays. The patient is noted to report his average pain at 3/10 to 4/10 at rest and 4/10 to 10/10 with activities. It is noted to increase with any activity but especially prolonged standing, sitting, or walking and driving. The patient is noted to previously treated with medications, ESIs, and physical therapy. He is reported to complain of pain both sides of the back, both buttocks, both hips, groin, and left leg numbness and tingling, foot pain. He did not report any weakness or atrophy. MRI reported to have been performed on 01/06/2014 is reported to show degenerative disc disease, a bulging disc, spinal stenosis, foraminal stenosis, facet degeneration, and hypertrophy at L3-4. X-rays performed on 01/31/2014 of the lumbar spine including flexion and extension views

noted an solid anterior fusion at L4-5 and L5-S1 without evidence of abnormal movement with flexion and extension. Incidental note was made of degenerative disc disease at L3-4 which was mild. X-rays of the pelvis performed on 01/31/2014 demonstrated postsurgical changes at L4-5 to L5-S1 with evidence of lateral fusion, the sacroiliac joints were symmetrical, and there was no bony erosion or destructive changes noted. A Letter of Determination non-certified the request for laminectomy, foraminotomy, and decompression of the nerve root at left L3-4 as the most recent radiographs of the spine showed no evidence of instability but noted disc space narrowing. The most recent physical exam did not provide specific exam findings. There was also no documentation regarding recent conservative care. In addition, the patient is noted to weigh approximately 400 pounds which would be a reasonable contributing factor for the patient's symptoms and it was unclear that if any weight loss attempts had been performed to date. Given the lack of clear clinical indications for surgical intervention, the reviewer did not recommend certification. A clinical note dated 03/13/2014 reported the patient is noted to have a thoroughly significant spinal history with an on-the-job injury in xxxx. He is reported to have undergone a fusion at the L4-5 level in 1999 and a second fusion at L5-S1 in 2000. He believed that the L4-5 level was redone as well. He was reported to have done fairly well after those surgeries although he did require the use of the back brace and reported that a number of months prior, without any particular trauma, he got out of bed and could hardly move and since that he had low back and leg pain. The majority of the pain was in his back itself but even there it was primarily on the left side, virtually all of the radiating pain he had was on the left and it radiated primarily to the left hip with some manifestation in the thigh. He also reported some pain in his left foot and very rare episodes of pain in the groin with certain movements. The patient is reported to have undergone conservative management including epidural steroid injections without significant improvement. Having already undergone 2 fusions to his back, the patient would like to avoid further fusion and he was seen to discuss minimally invasive options at the next level up at L3-4. A Letter of Determination reported while the patient complained of radiating low back pain there was no evidence in the medical record submitted of the patient's failure to respond to nonsurgical modalities for disc recurrence prior to his proposed lumbar decompression.

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

As there was no additional clinical documentation submitted for review with documentation of recent conservative treatment to address the patient's recurrent lumbar pain and in addition there is no documentation of a recent physical exam documenting clear clinical findings that support the need for surgery, the requested

lumbar laminectomy, foraminotomy, and decompression at left L3-4 remains non-certified and the previous decision is upheld.

IRO REVIEWER REPORT TEMPLATE -WC

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

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