

**True Decisions Inc.**  
**An Independent Review Organization**

**Phone Number:**  
**(512) 298-4786**

**512 W M L K Blvd. PMB 315**  
**Austin, TX 78701**

**Email: [truedecisions@irosolutions.com](mailto:truedecisions@irosolutions.com)**

**Fax Number:**  
**(512) 872-5099**

**Notice of Independent Review Decision**

**Case Number:**

**Date of Notice:** 11/17/2015

**Review Outcome:**

**A description of the qualifications for each physician or other health care provider who reviewed the decision:**

Orthopedic Surgery

**Description of the service or services in dispute:**

Right L4-L5 Laminectomy and Decompression  
Lumbar Brace

**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 health care service in dispute.**

Right L4-5 laminectomy and decompression is medically necessary  
lumbar brace is not medically necessary

**Patient Clinical History (Summary)**

The patient is a male who was injured on XX/XX/XX while delivering X. The patient injured his low back. Prior treatment had included the use of anti-inflammatories as well as tramadol for pain. The patient received epidural steroid injections with limited relief. The patient attended physical therapy for eight sessions. MRI studies of the lumbar spine from 08/11/15 noted loss of normal disc signal at L4-5 with a paracentral disc protrusion to the right with subligamentous migration causing thecal sac impingement and right lateral recess stenosis and impingement of the right L5 nerve root. Mild neural foraminal narrowing bilaterally was noted. The patient was followed for persistent pain in the right buttock radiating to the right thigh and calf. The patient reported no improvement with physical therapy injections or anti-inflammatories. The 08/26/15 report noted persistent pain in the right in the back and right lower extremity. The patient's physical examination noted 2+ and symmetric reflexes in the upper extremities. There was a blunted right S1 Achilles reflex. Straight leg raise signs were positive to the right. There was also mild weakness on great toe extension. Sensory loss was present in the right lower extremity. The proposed laminectomy decompression at L4-5 with a lumbar brace was denied by utilization review as there were no indications for the post-operative use of a lumbar brace for the proposed procedures and there was lack of full failure conservative management as well as a recent psychological evaluation.

**Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions**

***used to support the decision.***

In review of the clinical records the patient presents with objective evidence regarding a right L5 radiculopathy. MRI studies noted right L5 nerve root impingement due to a disc protrusion which correlated with the patient's physical examination findings that noted weakness, sensory loss, and reflex changes in an L5 in a L5 distribution. The documentation submitted for review notes failure of non-operative management to include physical therapy injections and medications. In regards to a psychological evaluation, Official Disability Guidelines does not indicate that psychological evaluations for patients who have failed a reasonable amount of conservative management is required. Therefore, it is this reviewer's opinion that medical necessity for the surgical request at L4-5 has been established and the prior denials are overturned in regards to this issue. In regards to the requested lumbar brace however, guidelines do not recommend routine post-operative use of lumbar bracing for decompression procedures only. There was no evidence the current literature establishing any improved post-operative outcomes with the use of a lumbar brace following decompression procedures only. Therefore, it is this reviewer's opinion that the lumbar brace requested is not medically necessary at this time.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
  
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)