

INDEPENDENT REVIEWERS OF TEXAS, INC.

2150 S. Central Expressway · Suite 200-264 · McKinney, Texas 75070

Office 214-533-2864 Fax 214-380-5015

e-mail: independentreviewers@hotmail.com

[Date notice sent to all parties]:

9/14/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right L5-S1 laminectomy.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Orthopedic Surgeon (Joint)**

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is an individual. On 11/18/14, an MRI of the lumbar spine noted that at L5-S1 there was desiccation and loss of normal water content, and there was a 4mm left L5-S1 disc herniation, with disc material filling the medial aspect of the left L5-S1 foramen. On 03/23/15, the patient returned to clinic. He had had a caudal epidural steroid injection performed on 02/19/15 and prior to that procedure, pain was rated at 3/10 and post-procedure pain was rated at 1/10. The patient reported pain had diminished by 50%. Symptoms included back pain. He reported occasional right foot pain as well. On 04/23/15, the patient returned. It was noted he had persistent right sided low back pain radiating to the right posterior thigh to the foot, and he had failed all conservative measures. A right L5-S1 laminectomy was recommended. On 07/20/15, the patient returned to clinic. It was noted he had been scheduled to undergo a right L5-S1 laminectomy but that procedure had not been certified. Pain scores remained minimal at 2/10 and maximum at 3/10. Pain was located on the right to the low back radiating to the right buttock, right thigh, and right calf. The recommendation was for a CT myelogram and further physical therapy.

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

On 06/19/15, a notification of adverse determination was submitted noting the request was for a right L5-S1 lumbar laminectomy. Guidelines utilized for that review were Official Disability Guidelines Low Back Chapter discectomy and laminectomy. It was noted the patient had been diagnosed with a strain in the lumbar region and lumbar herniated disc, and a peer-to-peer was not able to be performed. Therefore the request was non-certified. On 07/07/15, a notification of reconsideration adverse determination was submitted for the appeal for the right L5-S1 lumbar laminectomy, noting that the providers were in surgery and not available for review and discussion. It was noted there were no symptom changes reported and the previous determination noted that according to the guidelines, indications for surgery required symptoms and findings, imaging studies and conservative treatment. Therefore on appeal the request was non-certified. The records submitted for this review include electrodiagnostic studies suggesting involvement of the S1 root on the right side. The MRI of the lumbar spine notes that there is disc material to the left filling the medial aspect of the left L5-S1 foramen. The most recent record dated 07/20/15, notes the patient has radicular pain down his right lower extremity in a fashion consistent with the electrodiagnostic study. However, a complete objective examination of the patient documenting neurological deficits such as strength deficits, reflex changes and/or sensory changes, consistent with L5-S1 has not been provided. Guidelines indicate the procedure may be considered reasonable for those patients who have physical findings that correlate with imaging studies and who have failed lesser measures. Therefore, it is the opinion of this reviewer that the request for a right L5-S1 lumbar laminectomy is not medically necessary and the prior denials are upheld.

IRO REVIEWER REPORT TEMPLATE -WC

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

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG Indications for Surgeryä -- 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:

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).