



**REVIEWER'S REPORT**

**DATE OF REVIEW:** 06/10/07

**IRO CASE #:**

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

Lumbar L5/S1 laminotomy (hemilaminectomy) with decompression of nerve roots and partial facetectomy

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., Board Certified in Orthopedic Surgery

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

\_\_\_\_\_ Upheld (Agree)

  X   Overturned (Disagree)

\_\_\_\_\_ Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. Multiple denial letters from the insurance company
2. Records from the patient who is requesting this review, which really is just physical performance evaluation dated 03/28/07
3. MRI report
4. Surgical request form from treating doctor (TD) dated 04/02/07 in which he recommended fusion instrumentation of L5/S1 with lumbar laminectomy, 1 day length of stay, and purchase of a TLSO back brace
5. Clinic note dated 03/29/07
6. MRI scan of the lumbar spine dated 11/06/06 that shows grade 1 anterolisthesis with L5/S1 causing both canal and bilateral neural foraminal narrowing, greater on the right
7. Final followup note from TD when the patient came back after the surgery was denied on 04/12/07

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

One of the reasons for denial of this patient's services were the lack of a trial of epidural steroid injections. This patient is a diabetic, and this would not be a good idea. The patient has failed all other forms of conservative treatment and has objective findings of instability and neuropathy. Flexion/extension films would not really be helpful in light of the documented anterolisthesis and neural foraminal narrowing. Therefore, lumbar L5/S1 laminotomy (hemilaminectomy) with decompression of nerve roots and partial facetectomy is medically necessary in this case.

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

*(Check any of the following that were used in the course of your review.)*

- 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)