

# Clear Resolutions Inc.

An Independent Review Organization  
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Austin, TX 78726

## IRO REVIEWER REPORT TEMPLATE -WC

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### DATE OF REVIEW:

MAY 18, 2007

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar laminectomy left L4-5

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

MD Board Certified in Orthopedic Surgery

### 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 or not medical necessity exists for each of the health care services in dispute.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW

History and Physical Exam 3/29/07  
MRI Lumbar Spine without Contrast 3/8/07  
Prescription- 4/24/07, 4/17/07, 4/9/07  
3/1/07, 3/8/07  
Carrier Correspondence  
Denial Letter 4/4/07, 4/16/07  
Case Assignment

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The Patient is a male who claims while at work climbing a ladder, he somehow tripped and fell and landed on his back. As a consequence, he developed low back and bilateral leg pain to his ankle with the left being a great deal worse than the right. The Patient felt that his left leg was weak and he there was numbness in both legs. The Patient stated that the pain is getting worse. The Patient has had physical therapy.

Doctor's examination noted that lumbar flexion and extension is very limited by low back pain. Straight leg raising is noted to be quite painful at only a few degrees bilaterally with the left being a great deal worse than the right. Further noted that his gait is antalgic. After a neurological examination it was revealed that the Patient has normal strength in all motor groups distally and proximally. However, review of his lumbar MRI scan revealed a very large left paracentral L4-5 disc extrusion. This appeared to be a free fragment that had migrated slightly inferior to the disc space.

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

The request for a laminectomy at L4-5 to decompress this large disc herniation would appear to be medically necessary and reasonable. In general, the Official Disability Guidelines would suggest full conservative treatment for greater than two months is required. However, the Reviewer believes that this particular case does not fall well within the particular guidelines due to the very large nature of this disc herniation. It is noted to be 8 millimeter in size causing 50 percent spinal stenosis and several lateral recess stenosis. The treating physician has noted that there is a concern for cauda equina. Due to the nature of this particular case, the Reviewer would recommend approval of the surgery as requested, even within the two month time frame, despite the guidelines.

**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

Recommended for indications below. Surgical discectomy for carefully selected patients with radiculopathy due to lumbar disc prolapse provides faster relief from the acute attack than conservative management, although any positive or negative effects on the lifetime natural history of the underlying disc disease are still unclear. Unequivocal objective findings are required based on neurological examination and testing.

- 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)**