



DATE OF REVIEW: 12/26/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Lumbar laminectomy/discectomy.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of the spine-injured patient

REVIEW OUTCOME:

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

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. forms
2. referral
3. Utilization Management fax cover sheet
4. forms
5. Denial letters, 11/11/08 and 11/24/08
6. Utilization letter, 12/12/08
7. OA reviews, 11/11/08 and 11/24/08
8. request for preapproval fax cover
9. Clinical notes 11/07/08 and 11/10/08
10. , MRI scan lumbar spine
11. , lumbar spine films, 10/15/08
12. clinical notes, 10/15/08, 10/17/08, and 10/25/08
13. fax cover
14. TWCC-73

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This unfortunate xx-year-old male suffered a lifting injury to the lumbar spines on approximately xx/xx/xx. He was initially evaluated in the medical offices of . He was diagnosed with lumbar strain syndrome and eventually herniated nucleus pulposus at L5/S1. He has been treated utilizing physical therapy, nonsteroidal anti-inflammatory

medications, pain medications, and activity modifications. His symptoms and physical findings persist. He has low back pain and right leg pain. He has absent ankle jerk on the right side.

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

This patient's initial denials were based on the fact that the date of injury was within two months of the request for preauthorization of the surgical request. The patient, in fact, has a lifting injury with acute onset of low back pain and right leg pain. He has physical findings compatible with radiculopathy. His symptoms and physical findings have persisted in spite of appropriate nonoperative treatment. He has a herniated nucleus pulposus diagnosed and confirmed on MRI scan with mass effect in the region of the right S1 nerve root, which is appropriate finding considering the patient's physical findings. Laminectomy/discectomy should be approved for preauthorization.

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, 2008, Low Back Chapter, laminectomy/discectomy passage
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.)