



Notice of Independent Review Decision

DATE OF REVIEW: 5/2/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for surgery on L5-S1 - lumbar laminectomy, bilaterally.

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

Texas Licensed Neurological Surgeon.

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.

The previously denied request for surgery on L5-S1 - lumbar laminectomy, bilaterally.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- MRI of the Lumbar spine without contrast 12/26/06
- Doctors Notes dated 1/05/06, 1/22/08, 2/21/08
- Review of Medical History and Physical exam dated 3/4/08

- Medical Evaluation dated 3/4/08, 1/25/08
- CT L-Spine without contrast dated 2/18/08
- Myelogram L-Spine dated 2/18/08
- Follow-up Visit Chronic Opioid Analgesia dated 4/1/08
- UR Request dated 4/11/08, 3/21/08, 4/11/08, 3/21/08
- Invoice dated 4/25/08
- Request for review independent review organization dated 4/21/08
- Company Request for IRO dated 4/23/08

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years

Gender: Female

Date of Injury: xx/xx/xx

Mechanism of Injury: Fall from a rolling chair onto the floor.

Diagnosis: Herniated lumbar disc, L5-S1

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

This is a xx-year-old female with a date of injury of xx/xx/xx, when she fell onto the floor from a rolling chair. She was diagnosed with a disc herniation at L5-S1. She complained of pain that went down her right leg into the bottom of her foot. There was some pain in her left leg as well. She had physical therapy (PT), chiropractic care, epidural steroid injections, a TENS unit, and multiple medications. Her neurological examination was unremarkable. A post-myelo CT dated 02/18/2008, showed a small left paracentral disc protrusion at L5-S1; there were also degenerative changes at that level. The provider is recommending a bilateral L5-S1 laminectomy. The procedure is not medically necessary. The patient had no objective evidence of a radiculopathy, nor was there much evidence of a neurocompressive lesion on her CT myelogram. She may be experiencing discogenic back pain at L5-S1, but a laminectomy would not be the treatment for such a condition. According to the Official Disability Guidelines Indications for Surgery -- Discectomy/laminectomy -- Required symptoms/findings; imaging studies; & conservative treatments are symptoms/findings which confirm presence of radiculopathy to include quadriceps atrophy and weakness. The patient does not meet these criteria and therefore, medical necessity for a bilateral laminectomy is not supported. The denial is upheld.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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. ODG Treatment Index, 6th Edition, (web), 2008 – Low Back – Indications for laminectomy.
- 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 MEDICAL LITERATURE (PROVIDE A DESCRIPTION).
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).