

Clear Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 9, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Surgery L4-5 and L5-S1 laminectomy, foraminotomy, and discectomy with hardware removal

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

MD, Board Certified Orthopedic 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)

The reviewer finds that lumbar Surgery L4-5 and L5-S1 laminectomy, foraminotomy, and discectomy with hardware removal is medically necessary and the previous adverse determination(s) should be overturned.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 3/20/08, 4/9/08

ODG Guidelines and Treatment Guidelines

Insurance Verification, 4/2/08

DO, 3/28/08, 3/13/08, 2/12/08

CT Lumbar Spine without contrast, 2/27/08

Lumbar Myelogram and CT, 7/25/07

MD, 8/8/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is an injured worker who has had a previous low back fusion and developed onset of right-sided leg pain. He underwent a myelogram with post myelogram CT scan showing impingement underfilling of the right L5 nerve root sleeve. The EMG/nerve conduction study showed an acute right-sided radiculopathy. A previous reviewer has denied this surgery based upon the fact that the patient had not had an adequate home exercise program to help resolve this problem himself.

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

The treating physician has described the patient's radiculopathy with neurological deficit. The myelogram with post myelogram CT scan revealed "right L5 root sleeve does not fill out on the myelogram." The patient has findings compatible with that finding on the myelogram. There is also some indication of L5/S1 neural foraminal stenosis. The treating physician has recommended removal of the hardware on the right side in order to gain access to the L4/L5 and L5/S1 neural foramen, which is necessary in order to address the foraminal stenosis. There is weakness of the extensor hallucis in dorsiflexion on the right side at 3/5 according to the medical records, and this would be compatible with the findings of a myelogram. The patient is obviously well motivated as he did return to work full duty without restriction until this recent injury. It is for these reasons, given the fact that the patient has a mechanical problem documenting on imaging studies that correspond to the neurological findings on examination when the patient apparently, based on the records at least, would be well motivated, and not only does he have myelogram findings compatible with the neurologic exam, he also has a positive EMG/NCV study that rates this as an acute L5 radiculopathy. Hence, this is not from the previous operative intervention. Given the reasons stated above and based upon medical expertise and the ODG Guidelines, the reviewer finds that lumbar Surgery L4-5 and L5-S1 laminectomy, foraminotomy, and discectomy with hardware removal is medically necessary and the previous adverse determination(s) should be overturned.

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
- 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)