

Clear Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 13, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Laminectomy (Hemilaminectomy), with decompression of nerve root(s), including partial facet

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 4/2/08, 4/15/08

ODG Guidelines and Treatment Guidelines

Letter to IRO, 4/30/08

Spine & Rehabilitation, MD, 3/31/08, 3/27/08, 2/26/08, 12/18/07

Health Imaging, 11/26/07

Nerve Conduction and Electromyography, 12/4/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is an injured worker who, according to history, was originally injured in the low back. He was employed working in general maintenance and became entangled in a conveyor

belt, leaving him hanging. He sustained a degloving injury of his right upper extremity along with the low back injury. He reports daily low back pain radiating down the back of both legs to his feet. His pain comes on by walking. He has undergone an MRI scan, which reveals a 3-mm disc bulge without neural foraminal encroachment. He has had EMG/nerve conduction studies, which are said to be positive for bilateral L5/S1 radiculopathy.

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

The MRI scan is clearly noncompressive with no evidence of any neural foraminal stenosis on the MRI scan. It is for this reason that Laminectomy (Hemilaminectomy), with decompression of nerve root(s), including partial facet is not found to be medically necessary in this individual.

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)