

US Resolutions Inc.

An Independent Review Organization

71 Court Street

Belfast, Maine 04915

Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 28, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Laminectomy/ Diskectomy/Foraminotomy/Osteophytectomy/Medical Facetectomy & decomp L3-S1 (3 Levels)

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)

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 reviewer finds that medical necessity does not exist for Laminectomy/ Diskectomy/Foraminotomy/Osteophytectomy/Medical Facetectomy & decomp L3-S1 (3 Levels).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 9/23/08, 9/8/08
, MD, 9/15/08, 8/28/08, 8/5/08
MRI Lumbar Spine, 7/28/08
Radiology Report, 7/28/08
Myelogram, 8/25/08
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

This is an injured worker who was injured on xx/xx/xx with a diagnosis initially of a lumbar sprain. Apparently he was coming down a step from a natural gas well and slipped. His back apparently began to hurt. He continued with back pain radiating down into his left side, hip, and down his lower extremity to his toes. The physician notes that there is weakness of the extensor hallucis longus as well as dorsiflexion of the ankle, but no mention is made of weakness of the peroneals, and the other nerve root examinations are apparently normal. A diagnosis of an L5 radiculopathy has been made, and the impression is that this L5 radiculopathy is at the spinal level. It is for this reason that this surgery has been requested.

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

The MRI scan findings are of a normal L5/S1 level with “no significant abnormality.” The worst finding is at L3/L4 with the possibility of a “left exiting nerve root” compromise with a mild disc protrusion at L5/S1 with extension into the right neural foramen with a note of “may well be a degree of compromise at the exiting L5 nerve root on the right.” The myelogram with post myelographic CT scan documents similar findings, and more particularly document the lack of evidence of left L5 root compression. The treating surgeon’s own comments note that while the patient had clinical left L5 physical examination findings, that the imaging studies are not supportive of these particular findings at the spinal level. This request is for spine surgery with a view to decompressing the L5 root. However, not all L5 root radicular problems stem from an L5 root compression at the spinal level. Given this patient’s age and negative imaging findings, the guidelines support eliminating other potential causes of the problem prior to considering spine surgery. It is for all of these reasons that the reviewer finds that medical necessity does not exist for Laminectomy/ Discectomy/Foraminotomy/Osteophytectomy/Medical Facetectomy & decomp L3-S1 (3 Levels).

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)