

Notice of Independent Review Decision

DATE OF REVIEW: 12/11/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

63047 Lumbar laminectomy @ L4-5

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

The TMF physician reviewer is a board certified neurosurgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the 63047 Lumbar laminectomy @ L4-5 is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO
- Determination letter – 10/20/09, 10/30/09
- Encounter Summary by Dr. – 10/13/09

- IRO Summary – 12/03/09
- Employers First Report of Injury or Illness – xx/xx/xx
- Notice of Disputed Issue(s) and Refusal To Pay Benefits – 10/23/09
- Associate Statement – Workers Compensation – 04/16/09
- Emergency department record from Hospital – 04/15/09
- Office/Clinic Note by Dr. – 04/24/09 to 10/30/09
- OT evaluation– 04/29/09
- Therapy notes from Rehab – 05/04/09 to 05/14/09
- Report of MRI of the lumbar spine – 08/26/09
- Neuro-surgery office notes by Dr. – 10/15/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury when he fell striking the back of his head on xx/xx/xx. This resulted in a loss of consciousness and both cervical and lumbar strain. A CT scan in the emergency department indicated no intracranial pathology. The patient complains of lower back pain with numbness to his right leg. The treating neurosurgeon has recommended that the patient undergo a lumbar laminectomy at L4-5

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

This patient has symptoms and physical findings consistent with L4-L5 severe stenosis noted on an MRI scan. These symptoms and findings have not responded to conservative care including anti-inflammatory medications and physical therapy. The medical record documentation indicates that the patient has right foot dorsiflexion weakness and this surgery is medically necessary if this patient is to recover satisfactorily.

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)