



Notice of Independent Review Decision

DATE OF REVIEW: 12/4/09

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for left L4-5 minimally invasive laminectomy with 1 day inpatient stay.

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 left L4-5 minimally invasive laminectomy with 1 day inpatient stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice of Utilization Review Findings dated 11/19/09
- Company Request for IRO dated 11/19/09
- Request Form dated 10/21/09
- Request for Authorization of Spinal Surgery unspecified date

- Request for Preauthorized/Recertification unspecified date
- Preauthorization Determination Letter dated 10/13/09
- Peer Review dated 9/17/09
- Report/Letter dated 9/4/09
- Amended Report dated 9/4/09
- MRI Lumbar Spine dated 8/26/09
- Electromyography and Nerve Conduction Studies Report dated 8/26/09
- Neurological Consultation Report dated 7/22/09
- Report/Letter dated 7/1/09
- Exam: MRI of the Thoracic Spine Before and After Contrast dated 7/1/09
- Report/Letter dated 6/17/09, 5/15/09

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Motor vehicle accident

Diagnosis: Low back pain and status post laminectomy for herniated nucleus pulposus.

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

This male sustained an injury on xx/xx/xx. The mechanism of injury was a motor vehicle accident (MVA). He was status post right thoracic disc excision. His right-sided symptoms had improved. He now complained of low back pain with left leg pain. There was weakness in dorsiflexion. An MRI of the lumbar spine, on 08/26/09, revealed moderate spinal stenosis at L4-L5 with no encroachment of the exiting nerve roots or neuroforamina. The electrodiagnostic studies, dated 08/26/09, revealed mild chronic, but no active, bilateral L5 and L3-L4 radiculopathies. The provider is requesting a left L4-L5 minimally invasive laminectomy with a one-day inpatient stay. The left L4-L5 minimally invasive laminectomy with a one-day inpatient stay is not medically necessary. While there was some spinal stenosis at L4-L5, there was no encroachment on the nerve roots or neuroforamina. This did not correlate with the electrodiagnostic studies or clinical findings. According to the ODG, low back chapter, the indications for laminectomy state that the imaging studies should show, "One of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings: Nerve root compression...Lateral disc rupture, Lateral recess stenosis." This was not seen in this case. Therefore, based on the submitted documentation, the requested surgery is not medically necessary.

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.
Official Disability Guidelines (ODG), Treatment Index, 7th Edition (web), 2009, Low back – 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).