

Independent Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Fax: 817-549-0310

Notice of Independent Review Decision

DATE OF REVIEW: January 22, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for posterior lumbar decompression L5-S1 laminectomy foraminotomy

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

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

OD Guidelines

MRI lumbar spine, 08/12/08

Office note, Dr. , 09/08/08

Office notes, Dr. , 10/13/08, 10/20/08, 11/03/08, 11/17/08

EMG, 10/28/08

Injection, 11/10/08

Behavioral medicine evaluation, 11/24/08

Peer review, Dr. , 11/25/08

Peer review, Dr. , 12/16/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old female with complaints of low back pain and right lower extremity pain. The MRI of the lumbar spine from 08/12/08 showed a L5-S1 mild left sided neural canal narrowing secondary to 3-4 millimeter broad based posterior disc osteophyte complex which lateralizes to the left. The left neural foraminal and far left lateral component to the broad based disc osteophyte complex abuts but does not displace the exiting left L5 nerve root. There was a small central annular tear. Mild spondylosis of L3-4 and L4-5 without central or neural canal narrowing was reported. The 10/28/08 electromyography showed mild to moderate lumbosacral radiculopathy in either the L5 or S1 myotomes. Absent peroneal motor response was likely due to EDG atrophy. Abnormal right side lumbar and lower extremity electrography findings noted. Dr. examined the claimant on 11/17/08. Examination revealed 3-4/5 right extensor hallucis longus and 4/5 right anterior tibialis, 4+5 right gastrocnemius. Tension signs produced back and right thigh pain. Impression was foraminal stenosis at L5-S1. Dr. recommended posterior lumbar decompression L5-S1 laminectomy foraminotomy. The 11/24/08 psychosocial evaluation cleared the claimant for surgery.

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

The medical records still do not support an L5-S1 decompressive procedure based on the information reviewed.

The claimant's symptoms still do not correspond with the findings by MRI. The claimant has a paracentral herniation toward the left and has right sided radicular complaints. This has been noted in previous peer reviews and there is no further information from the treating surgeon.

ODG specifically requires imaging correlation with radicular findings/symptoms. Given the discrepancy noted, further information would be required to justify the surgical procedure that is requested.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, low back - **Lumbar Laminectomy/discectomy**

ODG Indications for Surgery™ -- Discectomy/laminectomy –Radiculopathy, weakness/atrophy, EMG optional, Imaging for correlation with radicular findings. Activity modification of 2 months and at least one of the following; NSAIDs, analgesic, muscle relaxants, ESI. Must have **one** of the following PT, chiro. Psychological screening, back school. Diagnostic imaging modalities, requiring ONE of the following: MR imaging, CT scanning, Myelography CT myelography & X-Ray

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)**