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Notice of Independent Review Decision

DATE OF REVIEW: July 7, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4-L5 and L5-S1 laminotomy (Hemilaminectomy) with nerve root decompression, including partial fasciectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted, inpatient two days

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

Certified by the American Board of Orthopaedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim Number	Review Type	Upheld/ Overturned
		Prospective	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Utilization review determination letter dated 5/20/09
 Reconsideration/appeal determination letter dated 6/8/09
 Request for Review by an Independent Review Organization
 Visit notes dated 3/28/08, 4/18/08, 5/21/08, 6/6/08, 6/13/08, 7/9/08, 8/13/08, 3/4/09,
 4/1/09, 5/6/0*, 6/22/09
 Operative report 08/22/08
 Letter of medical necessity dated 4/4/08
 Medical examination letter dated 4/01/08
 Electrodiagnostic interpretation 4/2/08

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MRI of the left shoulder report dated 3/25/08
Official Disability Guidelines

PATIENT CLINICAL HISTORY:

The patient is a xx-year-old male who suffered a work related injury to his back on xx/xx/xx. Records indicate the patient has leg pain radiating to the right leg. Treatment to date has included medications, epidural steroid injections and physical therapy. The patient previously underwent a right hemilaminectomy on 8/22/08. Progress notes dated 6/22/09 indicate the patient has complaints of right leg pain. A request for L4-5 and L5-S1 laminotomy was reviewed on 5/20/09 and denial was recommended. The Reviewer noted that there were no recent imaging studies; the previous diagnostic study was on 7/20/07. A reconsideration/appeal review was performed on 6/08/09, and upheld the previous denial, noting that the clinical data presented did not meet criteria per ODG guidelines.

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

In the Reviewer's opinion, based on the clinical information provided, the previous utilization review determinations are upheld as appropriate denials. The Reviewer noted that this injury occurred nearly 4 years ago, and the patient underwent right hemilaminectomy approximately 1 year ago. There are no current imaging studies submitted for review with evidence of recurrent disc herniation or nerve root compression. There is no evidence of motor deficit on most recent physical examination. The clinical data presented does not establish medical necessity for lumbar decompression per ODG criteria.

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**

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- 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)**