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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/20/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient Rt Lumbar Laminectomy/Discectomy, 63047, 77002, LOS x 1 day

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

M.D., board certified in Orthopedic Surgery

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

1. Adverse Determination letters, 06/09/09, 06/22/09
2. 06/09/09, 06/01/09, 06/14/09, 04/13/09
3. CT scan of lumbar spine, Chart Note, 06/01/09
4. MRI scan of lumbar spine, 05/20/09
5. Lumbar CT scan, 04/21/09
6. ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who is complaining of back pain with bilateral radiating leg pain and numbness. This is an apparently chronic condition that began some time ago in xx.xxxx. The patient has had an MRI scan and myelogram post CT scan, both showing essentially 2-mm central bulge at L4/L5. There was a normal EMG/nerve conduction study. Physical examination is reported to document right-sided iliopsoas weakness, not related to an L5 radiculopathy, as well as some weakness at L5 innervated muscle groups. The patient has had a previous epidural steroid injection, which apparently was of benefit. The patient has also had a psychological evaluation, which apparently was negative for obstruction to any surgical intervention.

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

This request for decompression of the right L5 root is difficult to support, given that the records show a minuscule disc protrusion at L4/L5, which would be expected in a normal individual. Furthermore, there is no documentation of a disc herniation. The patient has not had any selective nerve root sleeve blocks to document the L5 root as the offending actor, and physical examination shows findings including straight leg raising positive at 60 degrees on one side and 45 degrees on the other. These physical findings do not correlate with the MRI scan and myelogram findings. The innervated level for the iliopsoas does not show any findings on the MRI scan or myelogram. The request does not conform to the ODG statutory mandated treatment and disability guidelines. The requesting surgeon has not explained why an exception to those guidelines should be made. These guidelines as noted are clearly mandated in the Texas Labor Code. This patient has equivocal neurological findings including normal pinwheel sensory testing muscle evaluation. The iliopsoas weakness and apparent motor weakness on both the right and left side is stated to be 4/5, yet the surgery is only to address the right L5 root. Given the diagnostic imaging studies which are not supported of the requested surgery, the ODG Guidelines as mentioned cannot be set aside. We note from the guidelines specifically that there needs to be severe unilateral foot-toe dorsiflexion weakness or mild atrophy, which is not present in this case. It is this reviewer's opinion that the ODG criteria have not been met in this particular case and hence the reason for the decision. The reviewer finds that medical necessity does not exist for Inpatient Rt Lumbar Laminectomy/Discectomy, 63047, 77002, LOS x 1 day.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

- ACOEM-AMERICA 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)