

Notice of Independent Review Decision

DATE OF REVIEW: 03/08/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Bilateral Semi-Hemi Laminectomy @ L4-5, LOS 1 day

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

Certified by the American Board of Orthopedic Surgery and fellowship-trained in surgery of the spine.

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 #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	722.2	22554	Overturned
		Prospective	722.2	63030	Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physician notes dated 3/28/08, 2/15/08, 10/8/07, 1/24-26/07, 1/7/07

EMG/NCS report dated 3/12/08

X-ray reports dated 9/24/07, xx/xx/xx

Emergency Department visit 3/5/07

Treatment history

Official Disability Guidelines cited – Low Back-Lumbar & Thoracic (Acute& Chronic)
Discectomy/Laminectomy,

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PATIENT CLINICAL HISTORY:

According to the information provided, this claimant was injured on xx/xx/xx when lifting an object at work. Following evaluation on 1/26/07, acute lumbar strain with possible radiculopathy was diagnosed. Treatment has included oral pain medications and anti-inflammatory medications. The note of 2/15/08 noted that the claimant's low back pain is constant, that the leg pain comes and goes, and that the claimant took oral steroids without relief.

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

In the Reviewer's opinion, the requested procedure and 1 day LOS should be authorized as requested. This claimant has evidence of instability at L4-5 and combination instability/facet arthrosis syndrome at L4-5 (failure of the annulus at this level, resulting in a large L4-5 herniated disc). It is noted that the claimant has severe L4-5 radiculopathy and motor impairment of his quadriceps. The Reviewer noted that the claimant has failed all appropriate conservative care. Therefore, the proposed surgery is appropriate.

In conclusion, this claimant's clinical course and history (appropriate conservative care and over 2 years of severe pain) qualifies this claimant for the requested procedure pursuant to the Official Disability Guidelines.

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**

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- 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**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**