

# Clear Resolutions Inc.

An Independent Review Organization  
7301 RANCH RD 620 N, STE 155-199A  
Austin, TX 78726  
Phone: (512) 772-4390  
Fax: (512) 519-7316  
Email: resolutions.manager@cri-iro.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/29/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar laminectomy/discectomy L5-S1 with 2 days inpatient stay

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

M.D., board certified in Orthopedic Surgery and Spinal 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**

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker with complaints of low back and left leg pain with positive Lasegue's on the left and paresthesias in the S1 root distribution. There is no motor deficit. An MRI scan was performed on 12/04/08 and showed no abnormalities at the L4/S1 region. The EMG/NCV studies were performed and found to be normal. Other records showed noted no lumbar instability other than some facet subluxation. Current request is for lumbar laminectomy/discectomy.

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

Given the normal MRI scan findings reported by the radiology, the absence of EMG findings, and the absence of motor deficits, this patient does not conform to the Official Disability Guidelines and Treatment Guidelines as the radicular complaints, paresthesias, and pain have not been substantiated by objective diagnostic reports. While Dr. Earle noted on his review of the MRI scan there is a herniation, this has not been reported by the radiologist. Due to the absence of objective diagnostic testing confirming radiculopathy, this reviewer is unable to overturn the previous adverse determination as this request does not meet the Official Disability Guidelines and Treatment Guidelines. The reviewer finds that medical necessity does not exist at this time for Lumbar laminectomy/discectomy L5-S1 with 2 days inpatient stay.

**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)