

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 12/10/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assis

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assis are not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information requesting a review by an IRO – 12/01/10
- Letter of determination – 05/13/10, 06/10/10, 08/25/10, 11/11/10, 11/15/10, 11/17/10
- Orthopedic report by Dr. – 05/07/10 to 10/29/10
- History and Physical by Dr. – 03/29/10
- Initial Consultation by Dr. – 01/22/10
- Report of computerized muscle testing and range of motion – 05/07/10, 06/12/10, 08/13/10
- Report of MRI of the thoracic spine – 03/30/10
- Report of chest x-ray – 07/02/10
- Report of x-rays of the right elbow – 05/07/10
- Report of CT scan of the right elbow – 01/07/10
- Report of MRI of the lumbar spine – 12/22/09
- Report of x-rays of the lumbar spine – 12/19/10
- Surgery Reservation Sheet – 06/03/10, 11/08/10
- Telephone conference by Dr. – 11/09/10, 11/16/10
- Chapter 11, Microsurgical Anular Reconstruction (Anuloplasty) Following Lumbar Microdiscectomy, pp. 174
- Chapter 15, Repair of the Anulus Fibrosus (Anuloplasty) After Lumbar Discectomy, pp. 296
- Operative Report by Dr. – 06/08/10, 07/07/10, 08/31/10
- Dr. Procedure Orders – 06/08/10, 08/31/10
- Hospital Posting Sheet – 06/30/10
- Review Form by Dr. – 05/12/10
- Letter to from -CPS – 12/03/10
- Review results from, Inc. – 11/11/10, 11/17/10

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he slipped while walking on some reinforcement wire and fell backwards. This resulted in injuries to his right elbow, low back and cervical spine regions. The patient's right elbow injury resulted in a diagnosis of lateral epicondylitis and a right lateral epicondylectomy was performed on 07/07/2010. Symptoms of cervical pain and upper extremity pain appear to have resolved. Low back pain and lower extremity pain have persisted. Diminished sensation in the L5 dermatome on the right is reported. Straight leg raising is documented positive bilaterally. An MRI performed on 12/22/09 revealed broad based disc protrusion at the L4-L5 level which produces mild canal stenosis. Epidural steroid injections have been provided with transient relief of pain.

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

The patient lacks documentation of physical findings which would meet the ODG, 2010 criteria concerning L4 or L5 nerve root compression. Reflexes are present and symmetrical and there is no muscle weakness documented. Therefore, it is determined that the bilateral lumbar laminectomy and discectomy at the level L4-L5 would not medically indicated to treat this patient's condition.

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)