

SENT VIA EMAIL OR FAX ON  
Jan/11/2010

## Pure Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jan/11/2010

**IRO CASE #:**

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

Lt. Lumbar Laminectomy w/Injection @ L4/5

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

**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**

OD Guidelines

Denial Letters 11/23/09 and 12/18/09

Dr. 10/01/2009, 11/16/09

MRI of the lumbar spine report 8/27/09

Letter from 12/9/09

Family practice progress note 09/16/2009

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male with a date of injury xx/xx/xx, when he was shoveling feed and twisted his lower back. He complains of low back pain, radiating to the left lower extremity. He has had PT and medications. An MRI of the lumbar spine 08/27/2009 shows a broad-based disc protrusion at L4-L5 that causes a mild narrowing of the central and right lateral spinal canal with moderate narrowing of the left lateral spinal canal. There is a mild posterior disc bulge at L5-S1, with mild narrowing of the left neuroforamen. Neurological examination reveals a positive straight-leg raising on the left and decreased sensation on the dorsum of the left foot. There is weakness 4/5 in the extensor hallucis longus. The provider is recommending a left lumbar laminectomy with injection at L4-L5.

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

The procedure, as a whole, is not medically necessary. While the L4-L5 discectomy on the left appears to be indicated, given failure of conservative measures and objective evidence of

an L5 radiculopathy that correlates with neuroimaging, there is no need for an injection. The request does not specify what kind of injection is requested. However, based on the submitted documentation, the claimant is not a suitable candidate for any sort of injection, whether it be an epidural steroid injection, trigger point injection, or facet injection. Therefore, the procedure, as a whole, is not medically necessary.

### **References/Guidelines**

2009 *Official Disability Guidelines*, 14th edition

“Low Back” chapter

#### **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)