



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision

DATE OF REVIEW: 12/26/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Laminectomy, @ L4 with one day LOS on 11/18/09.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering spine problems

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
845.0	63047		Prosp.						Upheld

INFORMATION PROVIDED FOR REVIEW:

1. Independent Review forms
2. TDI referral forms
3. Denial letters 10/26/09 and 11/25/09, including criteria used in the denial.
4. Epidural steroid injection, 11/18/09
5. To Whom It May Concern letter, 10/27/09
7. Clinical notes, 10/08/09, 10/21/09
8. MRI scan, lumbar spines, 04/23/09
9. Pain management clinical notes, 07/01/09

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is a male who was involved in a motor vehicle accident on xx/xx/xx. He has suffered intermittent to constant low back pain and lower extremity pain, more severe on the right than on the left. He has a positive straight leg raising test on the right side. Deep tendon reflexes, patellar and Achilles, are diminished on the right side compared to the left. He has been treated with massage and activity modification. He has received a single epidural steroid injection. The result of the epidural steroid injection is not documented.

<p>P. O. Box 215 Round Rock, TX 78680 (1908 Spring Hollow Path, 78681) Phone: 512.218.1114 Fax: 512.287-4024</p>	
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ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

This patient may be suffering a form of spinal stenosis as a result of trauma and congenital narrowing of the spinal canal. The full extent of the diagnosis of canal stenosis is not clear. There is no clear documentation of treatment including modalities such as physical therapy, nonsteroidal anti-inflammatory medications, and other epidural steroid injections. The result of the single epidural steroid injection performed on 11/18/09 is not documented.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)

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