



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 12/15/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Laminectomy at L4-L5 and L5-S1

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

Board Certified – American Board of Psychiatry and Neurology

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.

Lumbar Laminectomy at L4-L5 and L5-S1 - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Lumbar Spine MRI, M.D., 01/08/09
- Evaluation, M.D., 07/21/09, 09/08/09

- Medical Documentation, M.D., 08/18/09, 08/26/09, 09/09/09, 09/23/09
- Daily Rehab Note, , 08/21/09, 08/20/09, 08/27/09, 09/03/09
- History/Physical, , 08/24/09, 09/24/09, 12/02/09
- Examination, , 08/24/09, 09/24/09, 12/02/09
- Range of Motion, , 08/21/09, 09/24/09, 12/02/09
- Treatment Plan, , 08/24/09, 09/24/09, 12/02/09
- X-ray Report, , 09/24/09
- Pre-Cert Request, xxxxxxxx 10/07/09, 11/04/09
- History & Physical Examination, xxxxxx, M.D., 10/22/09
- Denial Letter, , 11/09/09, 12/03/09
- Diagnosis Sheet, , 12/02/09
- Surgery Orders, Dr. M.D., Undated
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient had a history of lower back pain as a result of an injury that occurred on 11/08/08. He had undergone an MRI of his lumbar spine, physical therapy. It was not reported if he was on any medications.

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

According to ODG treatment guidelines, a lumbar laminectomy at L4-L5 and L5-S1 is not medically reasonable and necessary for this condition. The patient's MRI scan does not show evidence of spinal stenosis, but shows only disc protrusions at L4-L5 with no exiting nerve root impingement.

According to the ODG treatment guidelines, a lumbar laminectomy/laminotomy is recommended for lumbar spinal stenosis, which the claimant does not have. A discectomy was not recommended. A discectomy would be appropriate if there was clinical evidence of radiculopathy, which is also not confirmed by the medical records at this time. I have no objective evidence of a radiculopathy by clinical examination, and there is no historical evidence that an EMG was performed. As such, the procedure requested (lumbar laminectomy at L4-L5 and L5-S1) is not medically reasonable or necessary based on the ODG treatment guidelines as described above.

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)**