

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jun/23/2010

**IRO CASE #:**

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

Left Lumbar Laminectomy @ L5-S1, Discectomy, only Fusion & Possible pedicle screws

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

M.D., Board Certified Orthopedic Surgeon and Board Certified Spine Surgeon

**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**

Adverse Determinations, 4/22/10, 5/4/10  
Center for Neurological Disorders 4/16/10  
Insight 3/30/10  
3/22/10  
Medical Center 3/22/10, 3/26/10, 4/1/10  
4/22/10, 5/4/10  
AMR 4/21/10, 5/4/10  
ODG Treatment – Integrated Treatment/Disability Duration Guidelines – Low Back – Lumbar & Thoracic (Acute & Chronic)

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male who was injured in xx/xx when he was laying tiles on the floor and had pain in his back. The pain radiated down to the legs with some note of numbness and tingling into the feet. He had physical therapy. He apparently has not had invasive pain management. He has had nonsteroidal anti-inflammatory medication and pain medications. An MRI scan revealed that he had degenerative disc disease at L5/S1 along with a posterior disc bulge. There was no evidence of foraminal stenosis. He does not appear to have had flexion/extension films. There was a recommendation for a laminectomy at L5/S1 with discectomy only with fusion and pedicle screws.

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

This patient's situation does not conform to the generally accepted principles or the ODG for performance of a fusion. There have not been flexion/extension views. There has not been sufficient time since injury. There has not been a psychiatric evaluation, and there is no recommendation within the medical records as to why a fusion would be indicated. Furthermore, this patient does not have discrete definable neurological deficits that would warrant a laminectomy. In addition, the surgeon seems to be undecided as to whether

pedicle screws should be used, and this is not an intraoperative decision.

The patient does not meet ODG Guidelines for a discectomy/laminectomy due to the absence of neurological findings and the failure to perform selective nerve root blocks or epidural steroid injections. He does not meet fusion criteria due to the failure to have been treated for six months with conservative care and demonstrated structural instability on flexion/extension views, and, in addition, he has not had a psychological screen. Furthermore, the pain generator has not been identified through either invasive pain management or provocative discography techniques. It is for these reasons that the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist at this time for Left Lumbar Laminectomy @ L5-S1, Discectomy, only Fusion & Possible pedicle screws.

**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)