

SENT VIA EMAIL OR FAX ON
May/27/2010

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Laminotomy w/Decompression Nerve Root and Intraoperative neurophysiology testing

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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 3/5/10 and 3/22/10
Back 8/25/09thru 4/1/10
MRI 8/28/09
2/19/10

PATIENT CLINICAL HISTORY SUMMARY

He has back pain and bilateral leg pain.

He had prior psychological clearance for the procedure. Dr. described a L4/5 herniated disc without neurological loss. He has a positive right SLR. Dr. requested a lumbar discectomy as he failed 9 months of non-operative care including ESIs. The MRI showed a right paracentral disc herniation without "obvious nerve root compression."

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

The cited request is for a laminotomy, but Dr. requested a discectomy, which requires a

laminectomy. The ODG states the laminotomy is for spinal stenosis. That was not described. Presumably, there was the transcription error and a laminectomy/discectomy was actually requested. The ODG requires documentation of neurological loss in the form of atrophy or motor weakness according to the myotome involved. It accepts unilateral pain in the L4 or L5 dermatomes. Dr. notes that he has more right sided pain, but did not describe where in the right leg it is. The MRI did not confirm any nerve root compression. The entity of a chemical radiculitis may exist separate from a nerve root compression. In the absence of objective neurological findings, even with the failed conservative care, this man did not meet the criteria of the ODG for either a laminotomy or discectomy.

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)