

# I-Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Feb/18/2010

**IRO CASE #:**

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

Laminectomy from L3-S1 w/LOS x 1 Day 63047 63048

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

M.D., board certified in Orthopedic Surgery and Spinal 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**

ODG, Low Back Chapter, Indications for Surgery, Discectomy/laminectomy  
Adverse Determination Letters, 1/4/10, 1/15/10  
, 12/21/09, 12/7/09, 6/30/03, 1/5/10, 9/16/09  
M.D., P.A. 12/21/09  
12/21/09  
Open Air MRI 8/17/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a injured worker who, according to history, injured himself on xx/xx/xx. He was apparently lifting a PVC overhead and strained his back. He has tenderness and pain over the low back and pain at the sacroiliac joint on the right. On neurological examination he reportedly has no focal neurological deficits, no evidence of myelopathy, no clonus, no hyperreflexia, and no Hoffman's sign. There is evidence of a left S1 radiculopathy. There is no documentation of bowel or bladder problems. Proposed treatment is a laminectomy at L3 through S1.

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

While there is no question from this patient's medical records that there is significant central canal stenosis, it appears it is not causing any neurological deficit. Given the absence of neurological deficit and in particular myelopathy, the request for decompression at L3 to L5 does not meet Official Disability Guidelines and Treatment Guidelines. It is for this reason that the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for Laminectomy from L3-S1 w/LOS x 1 Day 63047 63048.

**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)