

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Oct/25/2010

**IRO CASE #:**

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

Laminectomy @ L4-5 L5-S1 63047 69990 63048 20931 38220

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

MD, Board Certified Orthopedic Surgeon  
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**

ODG Indications for Surgery – discectomy/laminectomy  
Workers' Comp Services 8/4/10, 9/1/10  
M.D. 7/20/10  
Diagnostic Center 4/27/07  
Imaging 6/16/10  
Medical Specialists 7/2/10  
Group 03/16/07 to 5/3/10  
Imaging 11/2/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male who was injured on xx/xx/xx. He had an immediate sensation of pain in his low back to the buttocks, down the right leg. He has had conservative management, including an epidural steroid that gave him great relief temporarily, but the pain came back. He has constant pain in his lower back that radiates to the buttocks, down the right leg to the right ankle, and numbness of the big toe, second and third toes on the right foot. His physical examination reveals positive straight leg raising bilaterally. His MRI scan reveals extruded discs at L4-5 and L5-S1. The current request is for two-level laminectomy.

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

A previous review of this case denied surgical intervention on the basis that there was no focal neurological deficit associated with the L5 and S1 dermatomes. However, based upon the Official Disability Guidelines for an S1 radiculopathy, it is noted that nerve root

compression requiring one of the following: severe unilateral foot so manifest hamstring venous atrophy, moderate unilateral toe/foot plantar flexion and hamstring weakness; unilateral buttock, posterior thigh/calf pain. As only one of the above three is required and this patient does manifest complaints of buttock and thigh/calf pain, he does in fact meet that criterion. He has a positive MRI scan compatible with his complaints and he has a neurological examination showing straight leg raising. His subjective complaints are compatible with an L5 and an S1 radiculopathy. He has been in the system for a great deal of time and has had exhaustive conservative care, including medications, epidural steroids, and physical therapy.

Based on my review of the criteria for the ODG Guidelines, he has in fact completed all the entry criterion for conservative care. He satisfies the imaging criterion; his physical examination satisfies the physical examination criterion. He meets the criterion of the ODG Guidelines for the requested procedure. It is for this reason that the previous adverse determination is overturned. The reviewer finds that there is medical necessity in this case for Laminectomy @ L4-5 L5-S1 63047 69990 63048 20931 38220.

**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)