

Notice of Independent Review Decision

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 11/15/10

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Lumbar laminectomy, L3/L4

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**  
M.D., Board Certified in Orthopedic Surgery

**REVIEW OUTCOME:**  
Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
			<i>Prosp.</i>						<i>Overturn</i>

**INFORMATION PROVIDED FOR REVIEW:**

1. Certification of independence of reviewer
2. TDI case assignment
3. Letters of denial, 09/24/10 and 10/28/10 including criteria used in the denials
4. Procedure report, 12/23/09, and radiology reports, 11/16/09 and 12/04/09
5. Preauthorization request, 01/11/10
6. Orthopedic consultation and follow up, 06/02/10 through 10/15/10

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The patient is a male who sustained an industrial injury on xx/xx/xx. He was given the diagnosis of lumbar herniated disc, lumbar stenosis, and low back pain. He was treated with medical management and epidural steroid injections. An MRI scan of the lumbar spine in xx/xx showed L3/L4 and L4/L5 broad-based disc bulges which touched and effaced the thecal sac. There was also facet hypertrophy and narrowing of the AP spinal canal diameter. Electrodiagnostic studies in March 2010 revealed bilateral L5 and S1 lumbar radiculopathy. The patient was also experiencing neurogenic claudication and failed injection therapy. An L3/L4 laminectomy was recommended, but it was denied by the insurance company due to incomplete correlation of subjective complaints through the objective findings.

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

I believe the decision should be overturned. The patient is a candidate for lumbar laminectomy at L3/L4 without fusion. The patient has pure radicular symptoms and has not responded well to conservative management. The request is medically reasonable and necessary and fits the ODG Guidelines.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)