

Clear Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Laminectomy/discectomy bilateral L5-S1; with one inpatient day (CPT Codes #63047, #77002)

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

MD, 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

ODG

Group 9/20/10, 9/24/10

M.D., F.A.C.S. 9/3/10 to 9/24/10

4/20/10, 9/25/09

County Surgical Group 8/18/10

Medicine Center 1/26/10

Hospital 9/3/10

9/17/10, 9/24/10, 2/9/10, 7/2/09

Neurosurgical Consultants 9/17/10

11/23/09

Imaging 4/6/09

Physicians Review Recommendation 11/6/09

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who has complaints of back pain and leg pain. The pain radiates down both legs, right greater than left. He was injured initially while lifting a mattress. He had a discogram, which revealed internal disc disruption syndrome at L4/L5 and L5/S1, and EMG/nerve conduction study showed bilateral L4 and S1 radiculopathy. Selective nerve root blocks at L5/S1 resolved his leg pain but not permanently. He had a myelogram with post

myelographic CT scan showing nerve root compression at L5 and S1. He had an MRI scan showing only a 2-mm diffuse L4/L5 disc protrusion. Request is currently for an L5/S1 decompressive laminectomy and microdiscectomy bilaterally.

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

This patient has previously been denied the requested surgery because the imaging study, (the MRI scan), was essentially normal with only a 2-mm disc bulge. However, a subsequent CT myelogram performed on 09/09 revealed severe L5/S1 disc disease and space to the left S1 nerve root, and therefore, this would be compatible with the EMG/nerve conduction study report. The patient also has neurological deficits in the lower extremity, i.e. loss of sensation over the S1 dermatome. This supports the myelogram findings where there was diminishing of the left S1 nerve root sleeve at the L5/S1 level with disc protrusion impinging upon both S1 roots and the thecal sac. It was noted there was severe left-sided L5/S1 foraminal stenosis. It was also noted that there was a bilateral L5/S1 facet hypertrophy with bilateral L5/S1 lateral recess stenosis. Indeed, there was a small disc bulge also at L4/L5. Due to the positive lumbar myelogram and post CT scan compatible with the patient's neurological picture and complaints – and due to the exhaustion of conservative care as delineated in the Official Disability Guidelines and Treatment Guidelines -- this patient does, indeed, meet the criteria for surgery in the guidelines. The reviewer finds that there is medical necessity for Laminectomy/discectomy bilateral L5-S1; with one inpatient day (CPT Codes #63047, #77002).

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)