

I-Decisions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Sep/07/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L2-5 decompressive laminectomy

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

Adverse Determination Letters, 4/29/10, 5/28/10, 3/23/10

M.D. 4/12/10

M.D. 4/29/10

MED R X 5/25/10, 5/24/10

M.D. 2/5/10 to 6/4/10

Regional Hospital 11/10/09

M.D. 12/2/08

EMG/NCS 12/16/09

BUMC 5/18/09

Medical and Surgical Associates 11/11/08 to 5/3/10

MyoVision Dynamic Report 3/3/09

ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a patient of with a work-related spine injury. Apparently he had a remote herniated disc surgery in xxxx. We are told that he has seen two surgeons who recommend surgery. His clinical complaints are those of low back pain and radiating leg pain going down the back of the legs down to the ankles and soles of his feet. Apparently it is worse on the right. He has some subjective weakness. He has had therapy, TENS unit, and medications but no epidural steroid injections or selective nerve root sleeve blocks. On 4/29/10, the insurance reviewer approved laminectomy at L4-5 with a posterior lateral fusion L4-5 without instrumentation with 3 day LOS. According to the URA the subject of this review is L2-5 decompressive laminectomy.

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

In this patient's history, there is no evidence that the patient is having any neurogenic claudication, and there is no indication from the history that this is a symptom that is participating in the patient's complaints. Furthermore, on the physical examination there is no hyperreflexia. The Babinski is said to be downgoing. There is no evidence of myelopathy in

the lower extremities. The patient also appears to have a relatively normal neurological examination. He is stated to have global weakness, 4+/5, throughout the lower limbs, i.e., actually affecting all the motor groups in the legs. There is a note that there is some lumbar stenosis of L1 through L5 with foraminal stenosis and disc herniation at multiple levels causing central compression of foraminal compression. There is a mild degree of spondylolisthesis noted at L4/L5. There is no indication in the medical record as to the degree of canal stenosis. Based upon the Official Disability Guidelines and Treatment Guidelines, this patient does not meet the criteria for L2-5 decompressive laminectomy. The medical records do not document any clinical symptoms of myelopathy and the physical examination does not reveal any clinical findings of myelopathy. The medical necessity for decompressing the central canal has not been established. It is for this reason that the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for L2-5 decompressive laminectomy.

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)