

Clear Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jul/06/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

63047 Lumbar Laminectomy @ L4-5, L5-S1; 63048 Addtl Level; 99221 Inpatient Hospitalization 1 Day

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

MD, Board Certified Neurosurgeon with additional training in Pediatric Neurosurgery

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-TWC Treatment Guidelines
Novare 5/4/11, 5/26/11
3/21/11 to 5/31/11
EEPPMC Oregon Imaging 1/18/11
NCV/EMG Study 4/1/11
Associates Statement 10/9/10
Associate Incident Log Form 10/6/10
10/16/10, 3/11/11
10/9/10
MD 10/11/10 to 2/15/11
PT Notes 10/19/10 to 1/12/11
Imaging Consultants 1/18/11
NP 1/28/11
Clinic 3/7/11 to 5/20/11
Technologies 3/21/11
3/24/11 to 5/12/11
Services Corporation 4/1/11 to 5/18/11
4/18/11 to 4/27/11

PATIENT CLINICAL HISTORY SUMMARY

This is a female with a date of injury xx/xx/xx, when she was carrying objects at work. She complains of back and bilateral leg pain with radiating pain down the left leg. In 03/2011 she had right leg symptoms and findings. She has undergone physical therapy, taken pain medications, and undergone pain management. An EMG 04/01/2011 reports bilateral L4 radiculopathy. Her neurological examination 05/17/2011 shows difficulty to stand or walk on

heels or toes. An MRI of the lumbar spine 01/18/2011 shows moderate canal and foraminal stenosis at L4-L5. At L5-S1 there is a left lateral disc protrusion with no canal or foraminal stenosis. She has undergone a psychological screen on 03/24/2011 and was found to have severe depression. Six individual counseling sessions were recommended. The provider is recommending a laminectomy at L4-L5 and L5-S1.

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

The requested surgery, as a whole, is not medically necessary. While the claimant has objective evidence of bilateral L4 radiculopathy and foraminal and central stenosis at L4-L5, the MRI of the lumbar spine shows no canal or neuroforaminal stenosis. Therefore, nerve root impingement at this level is not demonstrated. For this reason, then, the surgery as requested is not medically necessary. According to the ODG, "Low Back" chapter, "concordance between radicular findings on radiologic evaluation and physical exam findings" should be present in order for a lumbar laminectomy to be medically necessary. It is unclear that the L5-S1 level is responsible for the claimant's symptoms. Therefore, the procedure (63047 Lumbar Laminectomy @ L4-5, L5-S1; 63048 Addtl Level; 99221 Inpatient Hospitalization 1 Day) is not indicated or medically necessary.

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)