

SENT VIA EMAIL OR FAX ON
Mar/23/2012

Pure Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Mar/22/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
IP Left Decompressive Lumbar Laminectomy L4/5 3 day LOS

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Orthopedic spine surgeon, practicing neurosurgeon

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

OD Guidelines
Utilization review decision 02/15/12
Utilization review decision appeal 03/05/12
Pre-authorization appeal request 02/27/12
Appeal letter Dr. 02/22/12
MRI lumbar spine 01/30/12 and 10/26/06
Office note Dr. 01/31/12
Office notes Dr. 12/01/08-01/16/12
Procedure note lumbar epidural steroid injections 02/17/06 04/10/06 and 02/10/07
Designated doctor evaluation Dr. 07/17/07

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is xx/xx/xx. Records indicate the claimant was injured when he was lifting outrigger pads for an 80 ton crane and sustained injury to his lower back and left hip. Per designated doctor evaluation dated 07/17/07 the claimant

reached maximum medical improvement as of that date with 0% impairment. It was noted that the claimant states neither epidural steroid injection produced benefit. He has a negative EMG. He has no objective valid signs of radiculopathy. It was further noted that the claimant provided inconsistent effort during functional capacity evaluation with submaximal effort and was at an indeterminate PDC. Per Dr. office notes the claimant presents with chief complaint of low back pain, left lower extremity pain, left hip pain and chronic intractable pain syndrome. It was noted that the claimant was working full duty with no restrictions. MRI of the lumbar spine on 10/26/06 revealed a mild disc bulge at L4-5 with superimposed left subarticular left foraminal herniation that impinges the exiting L5 nerve root on the left. It was noted there was transitional anatomy with partial lumbarization of the S1 segment. Repeat MRI dated 01/30/12 revealed transitional anatomy at the lumbosacral junction with partial sacralization of L5. There are mild multilevel lumbar spondylitic changes. At L4-5 there is mild spinal canal stenosis with moderate left foraminal narrowing. At L3-4 there is mild to moderate right foraminal narrowing without spinal canal stenosis. The claimant was seen by Dr. for evaluation on 01/31/12. He was noted to complain of back pain and left leg radiculopathy. Physical examination on that date revealed the claimant to be 5'4½" tall and 146 pounds. He has normal gait. He has mild global decreased range of motion of the lumbosacral spine without significant pain with active range of motion testing. He had fairly symmetric and age appropriate bilateral hip, knee and ankle range of motion. There was no dermatomal specific sensory loss. There was no motor weakness. There was a tight hamstring and gastrocnemius complexes left greater than right. There was a pseudo positive straight leg raise on the left side. The claimant was recommended to undergo surgical intervention.

Per utilization review determination dated 02/15/12, a request for left decompressive lumbar laminectomy L4-5 with three day inpatient stay was non-authorized. The reviewer noted that the claimant does not demonstrate significant functional deficits as the medical record of 01/31/12 indicates there are no dermatomal specific sensory losses and no motor weakness. There is also a pseudo positive straight leg raise on the left side. The records submitted do not include a psychosocial evaluation as recommended by Official Disability Guidelines. It was noted that the request does not meet guidelines which indicate there should be radiculopathy that is correlated with imaging and there should be conservative care. There is a lack of documentation of significant functional deficits or significant radiculopathy. As such the request is non-certified.

Per utilization review decision dated 03/05/12, appeal request for left decompressive lumbar laminectomy L4-5 and three day inpatient stay was non-authorized. The reviewer noted that on 01/31/12 exam there are no objective findings to support a diagnosis of radiculopathy. Sensation and motor exam of the lower extremities were intact. The MRI does not report any nerve root compression at L4-5. The findings of mild central stenosis and moderate left foraminal stenosis alone do not provide any evidence for radiculopathy or significant nerve root compression. The request does not meet guidelines criteria and should not be certified.

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

Based on the clinical information provided, the proposed inpatient left decompressive lumbar laminectomy L4-5 with three day LOS is not supported as medically necessary. The claimant is noted to have sustained an injury on xx/xx/xx. He initially was treated conservatively including epidural steroid injections which provided no benefit. Records indicate that EMG was negative for radiculopathy. Designated doctor evaluation on 07/17/07 determined the claimant to have reached maximum medical improvement as of that date with 0% impairment rating. The claimant continued to complain of low back pain radiating to the left lower extremity. MRI of the lumbar spine performed 01/30/12 revealed transitional anatomy at the lumbosacral junction with partial sacralization of L5. At L4-5 there is mild to moderate disc bulge eccentric to the left with a small left central subarticular annular tear; bilateral facet osteoarthritis; mild spinal canal stenosis with mild right foraminal narrowing and moderate left foraminal narrowing. Physical examination on 01/31/12 revealed no motor or sensory deficit, or other findings indicative of radiculopathy. As such the claimant does not meet criteria for the proposed decompressive lumbar laminectomy. The previous denials were correctly

rendered and are upheld on IRO.

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)