

# True Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jul/16/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

STAT in-patient laminectomy, discectomy and foraminotomy at L4/5 and L5/S1 with three day length of hospital stay

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

Board Certified 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
Request for IRO  
Utilization review determination dated 05/03/12  
Utilization review determination dated 05/23/12  
MRI lumbar spine dated 07/06/11  
Radiographic report lumbar spine 06/16/11  
Clinical records Dr. 01/20/12-06/08/12  
Medical records Medical Center

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is male who is reported to have sustained work related injuries on xx/xx/xx. On the date of injury he was on a ladder, missed his step and started to have pains in his low back. Record indicate the claimant was referred for MRI of lumbar spine on 07/06/11. This study notes disc pathology at L2-3, L4-5 and L5-S1. At L4-5 there is a 1-2 mm disc protrusion with left paracentral 3 mm protrusion / herniation impinging on left anterior thecal sac and narrowing the medial aspect of left neural foramen. The disc protrusion also extends laterally to the right to more medial aspect of right neural foramen. At L5-S1 there is posterior 3 mm disc protrusion / herniation which presses on thecal sac narrowing medial aspect of neural foramina bilaterally with findings at this level accentuated by grade I retrolisthesis. Plain radiographs of lumbar spine were performed on 07/16/11 which notes degenerative joint disease and discogenic disc disease of lumbar spine.

On 01/20/12 the claimant was seen by Dr.. On physical examination the claimant is reported to have left lumbar radiculopathy and numbness. Motor functions are unchanged. Imaging studies are reported to show herniated disc at L5-S1 on left. The claimant was subsequently recommended to undergo laminectomy and discectomy at local surgery center. Records

indicate the claimant was seen in follow-up by Dr. on 01/27/12. He reported pain levels of 12/10. He reported medications are not helping and he reported difficulty with walking due to pain. He was recommended to undergo lumbar laminectomy and discectomy at L5-S1. Records indicate the claimant was seen in follow-up on 02/10/12 with no substantive change. On 05/04/12 it appears the claimant was admitted to Medical Center with intention of performing surgical intervention which was not approved under utilization review. On 05/11/12 the claimant was seen in follow-up and the claimant's lumbar laminectomy was reported to have been denied by insurance company. The claimant reported medications are not helping much. On physical examination he is reported to have pain in the left leg with numbness, a decreased left ankle jerk, straight leg raise is 80 degrees on the right and 40 degrees in the right leg. He is again recommended to undergo laminectomy and discectomy at L5-S1.

On 06/08/12 the claimant was seen in follow-up. He is noted to have continued low back pain with left leg pain and a burning sensation to the foot. He is reported to have severe and excruciating pain in the left leg down to the toes with no other deficits. He is again recommended to undergo a laminectomy discectomy.

The initial review was performed on 05/03/12. At this time the reviewer notes that the claimant has complaints of low back pain with a VAS score of 15-20/10 radiating into the bilateral lower extremities moreso in the left leg. He notes that the last comprehensive physical examination dated 04/23/12 revealed midline lumbar and right lumbar paraspinal muscle tenderness with limited range of motion. Sensation and deep tendon reflexes are intact. Straight leg raise is reported to be positive on the left. He notes that the claimant is reported to have severe low back pain but has good range of motion in all extremities and stable vital signs. The claimant was admitted for pain management. He notes there is a lack of correlation between imaging and subjective complaints and that all possible pain generators have not been evaluated. It is recommended that a psychological evaluation be performed. The appeal request was reviewed.

The appeal request was reviewed on 05/23/12. At this time the reviewer non-certified the request noting an adverse determination in the previous review and noting a lack of documentation of failure of conservative treatments. The reviewer notes that there is no documentation of additional findings of radiculopathy on examination and subsequently non-certified the appeal request.

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

The request for staff inpatient laminectomy, discectomy and foraminotomy at L4-5 and L5-S1 with three day length of stay is not medically necessary and the prior determinations are upheld. The available medical records indicate that the claimant sustained a work place injury which has resulted in low back pain with radiation into the left lower extremity. The claimant has undergone imaging study which suggests the presence of possible pathology at L4-5 and L5-S1 with the findings at L4-5 being more prominent. The record contains absolutely no clinical information to establish that the claimant has undergone any form of conservative treatment. There is no indication that the claimant has participated in physical therapy or received epidural steroid injections. The claimant has no objective evidence presented on physical examination which indicates that he has a rapidly progressing neurocompressive lesion which would warrant surgical intervention without conservative management. Therefore, based upon the submitted clinical information, the request cannot be supported as medically necessary and does not meet Official Disability Guidelines.

**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)