

US Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/20/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Re- Exploration L4-5 Foraminotomy/Discectomy

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

M.D., Board Certified Orthopedic Surgeon, 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. The reviewer finds Re-Exploration L4-5 Foraminotomy/Discectomy is not supported as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

UR Denial 05/25/12

UR reconsideration uphold 06/14/12

Office notes Dr. 01/06/11-06/22/11

Clinic / progress notes Dr. 01/06/11-05/18/12

MRI lumbar spine 05/24/11

Neurology evaluation and EMG/NCV Dr. 02/28/12

Lumbar spine x-rays 01/21/12

MRI thoracic spine 04/12/12

Optimum rehabilitation spine evaluation 08/29/11

Designated doctor's evaluation Dr. 01/27/12

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a male whose date of injury is xx/xx/xx. He attempted to open a door by pulling on a chain. The chain broke causing him to fall backwards and he landed on his buttocks. He had lumbar laminectomy in 1999. On 07/06/11 the claimant underwent T11-12 laminectomy and L4-5, L5-S1 reexploration laminectomy. He continued to complain of low back pain radiating down his right lateral thigh and leg with right foot numbness. Progress note dated 05/18/12 noted the claimant does not want to have injections. Medications were listed as Neurontin 300 mg 3 times a day and Lyrica 75 mg 3 times a day. Electrodiagnostic testing performed 05/24/11 reported abnormal lower extremity NCV consistent with mixed

sensory motor neuropathy with axonal and demyelinating components. There is also an abnormal EMG consistent with acute denervation effect in right L5 distribution.

A request for reexploration L4-5 foraminotomy / discectomy was denied by utilization review dated 05/25/12 noting that no formal imaging report was available documenting recurrent nerve root compromise. A reconsideration request was denied per utilization review dated 06/14/12 noting the requesting physician cannot locate any recent physical diagnostic finding to correlate with L5 radiculopathy with no documentation of positive straight leg raise exam or any motor / sensory deficits. It was also noted there is no documentation of a positive transforaminal diagnostic epidural. In this case Official Disability Guidelines would not be satisfied for medical necessity revision decompression. Although there has been some conservative treatment, the objective evidence of L5 involvement on clinical examination is lacking.

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

This man was injured on xx/xx/xx when he pulled a chain, and the chain broke causing him to fall backwards. He has a history of previous lumbar laminectomy in 1999. He is status post T11-12 laminectomy and L4-5, L5-S1 reexploration laminectomy on 07/06/11. The claimant continued to complain of low back pain and right lower extremity pain with right foot numbness. There is no postoperative MRI submitted for review with objective evidence of disc herniation. Electrodiagnostic testing on 02/28/12 reported findings consistent with right L5 radiculopathy; however, as per the guideline recommendations no physical examination findings were documented with evidence of right lower extremity radiculopathy such as positive straight leg raise, motor deficits, or sensory changes. Therefore, the reviewer finds that Re- Exploration L4-5 Foraminotomy/Discectomy is not supported as 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)