

I-Resolutions Inc.

An Independent Review Organization
8836 Colberg Dr.
Austin, TX 78749
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/02/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

outpatient lumbar laminectomy at left L3-4 and L4-5 with length of stay for one day and assistant surgeon

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines and Treatment Guidelines
Request for IRO dated 12/15/11
Request for IRO dated 12/13/11
Utilization review determination dated 10/07/11
Utilization review determination dated 11/23/11
Clinical records Dr. dated 12/08/11, 07/25/11, 05/31/11
EMG/NCV study dated 07/19/11
Procedure report caudal epidural steroid injection dated 06/27/11
MRI lumbar spine dated 04/12/11
Radiographic report lumbar spine dated 04/12/11
Clinical records Dr. dated 02/22/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained work related injuries to his low back on xx/xx/xx. On this date he is reported to have been carrying a. Upon setting it down he felt low back pain causing him to fall to his knees. On physical examination he is reported to have low back pain and was placed on medications Norco 10/1325, Soma and Neurontin 300 mg. He was referred for MRI of lumbar spine, which notes left posterolateral disc protrusion at L4-5 with moderate secondary inferior foraminal stenosis. Radiographs of lumbar spine show mild annular disc bulge at L3-4 and L4-5. He is status post 6 weeks of physical therapy and medication management without significant improvement. He has pain and numbness radiating into left shin. He has history of previous back injuries in xxxx from fall and in 2004 had conservative treatment with physical therapy and injections. Physical examination indicates tenderness over facet joints at L3-4 and L4-5, paravertebral muscle spasm and 4/5 weakness in left EHL. Otherwise motor strength is intact with negative straight leg raise.

MRI was reviewed and reported to show small to moderate disc protrusions at L3-4 and L4-5 with facet hypertrophy. The claimant was referred for caudal epidural steroid injection on 06/27/11. This is reported to have only transient effect. The record includes EMG/NCV dated 07/19/11, which notes presence of lumbosacral radiculopathy at L4-5 on left.

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

This man injured his lower back and has not responded to well-documented conservative treatment. He has not improved with medications, physical therapy or caudal epidural steroid injection on 06/27/11. EMG/NCV study confirms the presence of a left L4 L5 radiculopathy. He has failed conservative management and there is objective evidence of a left lower extremity radiculopathy validated by electrodiagnostic studies. Therefore, the reviewer finds the requested outpatient lumbar laminectomy at left L3-4 and L4-5 with length of stay for one day and assistant surgeon is 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)