

Pure Resolutions LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/11/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient lumbar laminectomy at left L5/S1 with tissue grafts and marrow aspiration and estimated one day length of stay

A 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)

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
Procedures notes dated 10/01/11 and 12/12/11; MRI study with reports from Dr. and Dr. dated 08/08/11; clinical notes dated 10/18/11 – 08/14/12; Prior reviews dated 07/24/12 – 08/22/12; cover sheet and working documents.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx and has been followed for complaints of low back pain radiating to the left lower extremity. MRI of lumbar spine dated on 08/08/11 revealed a focal central posterior 3mm fissure at L5-S1. There was mild left foraminal stenosis secondary to facet hypertrophy. This finding was dictated by Dr. A second report by Dr. for the same MRI study identified contact of the left L5 nerve root due to facet arthropathy and the disc protrusion noted. Dr. opined that there was moderate stenosis of the left lateral recess and mild to moderate stenosis of left neural foramina. The patient did undergo epidural steroid injection which decreased the patient's symptoms by approximately 50%. Clinical evaluation 07/17/12 stated that the patient continued to have low back pain radiating to the left buttock, thigh and calf but did not extend below the left calf. Other treatments have included chiropractic manipulation for 20 sessions. Physical examination at this visit revealed poor range of motion of the lower extremities with mild weakness noted in the left extensor hallucis longus. Sensation was intact. New MRI studies were recommended at this visit. Follow up on 08/06/12 indicated that MRI studies were denied by Utilization

Review. Physical examination was relatively unchanged. Prior non-operative measures were again reviewed to include anti-inflammatories, physical therapy, activity modifications and 2 epidural steroid injections with no significant long term improvement. Follow up on 08/14/12 reported continuing weakness of the left extensor HL and has not changed in severity. The request for lumbar laminectomy at the left L5-S1 level with tissue graft, marrow aspiration and estimated one day length of stay was denied by Utilization Review on 08/09/12 as there was no correlation of clinical and radiographic findings. The request was again denied by Utilization Review on 08/22/12 as there was only minimal weakness and no reflex abnormalities as best and equivocal MRI finding.

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

The requested lumbar laminectomy to the left at L5-S1 with tissue grafting, marrow aspiration and estimated on day length of stay is not recommended as medically necessary. The clinical documentation submitted for review provides insufficient objective evidence to clearly support a diagnosis of lumbar radiculopathy that has been refractory to conservative treatment. The clinical documentation provided 2 separate MRI reports for the August, 2011 study. They are conflicting reports and the patient physical exam findings are relatively unimpressive and do not clearly identify pain generators in the lumbar spine. There was no further diagnostic testing such as electrodiagnostic studies to further delineate the patient's pain generator confirming a diagnosis of lumbar radiculopathy that would reasonably support the request the requested surgical interventions. Given the lack of clear objective evidence to support a diagnosis of lumbar radiculopathy, medical necessity would not be established at this time and the prior outcomes are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES