

# Pure Resolutions LLC

An Independent Review Organization

990 Hwy 287 N. Ste. 106 PMB 133

Mansfield, TX 76063

Phone: (817) 405-0514

Fax: (512) 597-0650

Email: [manager@pureresolutions.com](mailto:manager@pureresolutions.com)

## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

Dec/03/2013

### IRO CASE #:

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

Outpatient Left L5/S1 Laminectomy

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

Board Certified Neurosurgery

### 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:

ODG - Official Disability Guidelines & Treatment Guidelines

MRI of the lumbar spine dated 08/09/13

Clinical note dated 08/28/13

Clinical note dated 09/23/13

Adverse determinations dated 09/30/13 & 10/16/13

### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury regarding his low back when he noted a popping sensation in his back and noticed immediate pain in the back radiating to both lower extremities. The MRI dated 08/09/13 revealed a posterior central disc herniation measuring 10mm at the L5-S1 level with a subtle left lateralization. Minimal contact of the traversing left S1 nerve root sleeve was noted without central spinal canal stenosis. The clinical note dated 08/28/13 indicates the patient rating his low back pain as 4/10 at that time. The note indicates the patient utilizing Mobic, Zanaflex, Tramadol, and Hydrocodone for pain relief. Upon exam, the patient was noted to have stiffness as well as an aching sensation in the low back. The patient described the pain as a sharp, shooting, and aching pain. The patient stated the pain was affecting his sleep and work as well as recreational activities. Coughing, sneezing, and changing positions exacerbated the patient's pain. The patient was noted to rise from a seated position with discomfort. The patient was noted to be ambulating with a pitched forward antalgic gait. Dysesthesia was noted in both lower extremities specifically in the L5 and S1 distributions. An absent reflex was noted at the left Achilles. The clinical note dated 09/23/13 indicates the patient continuing with 5/10 pain. The patient was recommended for a laminectomy at the L5-S1 level at that time.

The utilization review dated 09/30/13 resulted in a denial as no documentation was provided

indicating the patient had completed a course of conservative care.

The utilization review dated 10/16/13 resulted in a denial for an L5-S1 laminectomy as no information was submitted regarding the patient's previous involvement with conservative treatments.

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

The documentation submitted for review elaborates the patient complaining of low back pain with associated dysesthesia in the lower extremities. A laminectomy would be indicated in the lumbosacral region provided the patient meets specific criteria to include completion of all conservative treatments. There is mention in the clinical notes regarding the patient's use of pharmacological interventions. However, no information was submitted regarding the patient's completion of a course of conservative therapy. Given that no indication has been provided regarding the patient's completion of any conservative therapies, this request is not indicated. As such, it is the opinion of this reviewer that the request for an L5-S1 laminectomy on the left is not recommended 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)