

Clear Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/26/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: laminectomy bilateral L4-5

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery, Fellowship Trained Spine Surgery

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. It is the opinion of this reviewer that medical necessity for laminectomy bilateral L4-5 is not established

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx. Prior conservative treatment included physical therapy and epidural steroid injections which provided minimal relief only. Medications included anti-inflammatories, muscle relaxers, and tramadol for pain. Original MRI of the lumbar spine from 06/18/11 noted 1.7mm disc bulge at L4-5 with minimal neural foraminal encroachment. No facet pathology was identified. The patient continued to report severe low back pain radiating to the lower extremities right worse than left with any standing or walking for an extended period of time. The patient described ongoing numbness in the bilateral lower extremities. Updated imaging from 02/07/14 was done. Radiographs of the pelvis were reported as reported normal findings. MRI or radiographs of the lumbar spine noted mild spondylitic changes at L4-5 and L5-S1. No instability or spondylolisthesis was identified. MRI of the lumbar spine noted mild disc height loss at L4-5 with diffuse disc bulging contacting traversing right contacting the bilateral traversing L5 nerve roots. No canal stenosis was identified. There was some mild left and mild to moderate right neural foraminal stenosis. Clinical record on 03/11/14 noted no motor weakness sensory changes or reflex deficits. Recommendations were for decompression at L4-5 including laminectomy. The requested L4-5 laminectomy was denied by utilization review on 03/20/14. Per the report surgery was recommended however there were corresponding requests for dural grafting and a lumbar support orthosis which was not supported and therefore the request as submitted was non-certified. The request was again denied by utilization review on 04/18/14 as there was inconsistent documentation regarding lumbar radiculopathy and lack of clear evidence regarding neurocompression.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND

CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for ongoing complaints of severe low back pain radiating to the lower extremities. Imaging noted degenerative disc disease at L4-5 with a disc bulge contacting the traversing right traversing bilateral L5 nerve roots. There was some neural foraminal stenosis mild to moderate to the right and mild to mild left. Physical examination findings for the patient were somewhat inconsistent. Over multiple providers there was no clear evidence of an L4 or L5 radiculopathy. The most recent evaluation noted no motor weakness, reflex changes, or sensory deficits. Per guidelines there should be correlating findings between physical examination and imaging regarding lumbar radiculopathy to support surgical intervention. No other diagnostic testing was available for review such as EMG to confirm presence of L4 or L5 radiculopathy. Although the patient has not improved with conservative management given the insufficient objective evidence regarding lumbar radiculopathy, it is the opinion of this reviewer that medical necessity for laminectomy bilateral L4-5 is not established based on guideline recommendations. As such the prior denials are upheld.

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)