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Notice of Independent Review Decision

DATE OF REVIEW: June 5, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Removal spine lamina 1 lumbar.

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

M.D., Board Certified in Orthopedic 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)

I have determined that the requested removal spine lamina 1 lumbar is not medically necessary for the treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury on xx/xx/xx, and the mechanism of injury involved a fall. On xxxxx, magnetic resonance imaging (MRI) of the lumbar spine demonstrated L3-4 and L4-5 disc herniations, L4-5 moderate right and mild left bilateral neural foraminal narrowing, and L3-4 mild bilateral neural foraminal narrowing. The current diagnoses include C4-5 and C5-6 disc herniations, C6-7 spinal cord abutment without spinal cord signal change, a left 1.9 cm thyroid nodule, L3-4 and L4-5 disc herniations, and L4-5 moderate right and mild left

bilateral neural foraminal narrowing. On 7/29/13, the patient reported persistent neck and lumbosacral spine pain. He has been previously treated with physical therapy. His current medications included ibuprofen. Physical examination of the lumbar spine revealed limited lumbar range of motion, tenderness to palpation, negative straight leg raise test, and normal deep tendon reflexes. Treatment recommendations at that time included a possible epidural steroid injection in the cervical spine. A request has been submitted for removal spine lamina 1 lumbar.

The URA indicated that the patient does not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the initial denial stated that there are no significant findings of radiculopathy on examination to correlate with the findings on MRI. Per the URA, the foraminal narrowing at L3-4 is mild, and it is unclear what conservative measures the patient has undergone for his condition. On appeal, the URA indicated that the patient has chronic complaints of back and leg pain. However, the details of the subjective complaints are not noted. Per the URA, documentation of prior treatments including nonsteroidal anti-inflammatory medications, muscle relaxants and/or an epidural steroid injection are not provided.

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

The Official Disability Guidelines (ODG) state prior to a discectomy/laminectomy, there should be evidence of radiculopathy upon physical examination. There should be documentation of nerve root compression, lateral disc rupture, or lateral recess stenosis upon imaging studies. Conservative treatment should include activity modification, drug therapy, and epidural steroid injections. There should also be evidence of a referral for physical therapy, manual therapy, or completion of a psychological screening. As per the documentation submitted, the patient currently utilizes ibuprofen, and he has also been previously treated with physical therapy. The MRI of the lumbar spine dated 7/16/13 does indicate mild bilateral neural foraminal narrowing at L3-4 and L4-5. However, the patient's physical examination only revealed limited range of motion with tenderness to palpation. Per the medical records, he demonstrated negative straight leg raising, normal deep tendon reflexes, and intact sensation. Without objective evidence of radiculopathy, the requested services are not medically indicated.

Therefore, I have determined the requested removal spine lamina 1 lumbar is not medically necessary for treatment of the patient's medical condition.

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

- ACOEM- AMERICAN 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 JUDGMENT, 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)**