

Pure Resolutions LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Oct/1/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient left sided L4-5 minimally invasive lumbar decompression

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

DO, Board Certified 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury to his low back. No information was submitted regarding a description of the initial injury. The MRI of the lumbar spine dated 02/14/13 revealed a minimal tear of the annulus fibrosis at L4-5 with no focal disc bulge or any disc protrusion. The CT myelogram of the lumbar spine dated 05/12/14 revealed a rightward protrusion of the L4-5 disc without central canal or neuroforaminal stenosis. The clinical note dated 06/27/14 indicates the patient complaining of low back complaints. The note indicates the patient utilizing Hydrocodone. The patient stated that he cannot sit or stand for any prolonged period of time. The clinical note dated 07/23/14 indicates the patient complaining of radiating pain from the low back into the left lower extremity. The patient rated the pain as 5-8/10. There is an indication the patient has undergone the use of Norco, physical therapy, as well as injections. The note indicates the injections providing short term benefit only. The clinical note dated 08/18/14 indicates the patient continuing with complaints of palpatory tenderness in the lumbosacral junction. The patient was identified as having a positive straight leg raise at 45 degrees. The clinical note dated 07/23/14 indicates the patient being recommended for an L4-5 decompression.

The utilization review dated 08/19/14 resulted in a denial as no significant pathology had been confirmed by the imaging studies.

The utilization review dated 09/04/14 resulted in a denial as no significant symptoms were identified confirming the patient's radiculopathy.

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

The documentation indicates the patient complaining of low back pain. A decompression in the lumbar region is indicated for patients who have ongoing symptoms consistent with radiculopathy in the lower extremities following a full course of conservative therapy and imaging studies confirm the patient's significant pathology. There is an indication the patient has complaints of low back pain. However, no information was submitted regarding the patient's strength, sensation, or reflex deficits in the lower extremities. Additionally, no information was submitted regarding the patient's imaging studies confirming the patient's neurocompressive findings. Without this information in place, the requested surgical procedure involving an L4-5 decompression is not supported. As such, it is the opinion of this reviewer that the request for an L4-5 decompression 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)