

# Becket Systems

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Apr/01/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Lumbar L3-L4 laminectomies for decompression with L3-L4 discectomy, unspecified length of stay

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O., Board Certified Neurological 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 this reviewer's opinion that the request for a lumbar L3-4 laminectomy for decompression with L3-4 discectomy and an unspecified length of stay is not medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** This patient is a xx year old with back pain. On xx/xx/xx, an MRI of the lumbar spine revealed at L3-4, there was severe disc narrowing, marginal osteophytosis, mild end plate bony remodeling, and type 1 end plate changes on the right. There was asymmetric annular bulging, most prominent on the left far laterally. There was mild left facet arthrosis. There was severe right and moderate left neuroforaminal stenosis. No central canal stenosis was identified at that level. On 02/18/15, the patient was seen in clinic and noted the exam with essentially no change from the previous one of 11/26/14. That exam found there was no change from the exam of 10/20/14. Once again it was noted there was diminished strength and sensation in the right lower extremity with limited range of motion of the lumbar spine.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** On 01/28/15, a utilization review determination stated the requested procedure was not medically necessary as the examination was not available for review as the 08/18/14 exam noted that the physical examination was unchanged when compared to 11/18/13. Therefore the request was non-certified. On 02/25/15, a utilization review determination stated that while the records alluded to the patient having motor weakness on the right lower extremity the records do not specifically identify myotomal distribution or altered sensation in the right lower extremity without noting the distribution. Therefore there was a lack of focal neurological deficits correlating with imaging studies for the requested L3-4 laminectomy and discectomy and the procedure was not medically necessary.

For this review, the records also indicate that the patient was seen on 02/18/15, and it was noted the exam was essentially unchanged from the previous evaluation of 11/26/14. Once again it was noted there was diminished strength and sensation in the right lower extremity.

This was in a non-dermatomal distribution and non-myotomal distribution. Guidelines indicate the procedure may be considered reasonable if there is documentation of physical findings that correlate with imaging studies. Therefore without documentation of specific distribution of the motor deficits or sensory changes, this request is not supported. Therefore, it is this reviewer's opinion that the request for a lumbar L3-4 laminectomy for decompression with L3-4 discectomy and an unspecified length of stay is not medically necessary and 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)