

Clear Resolutions Inc.

An Independent Review Organization

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DATE NOTICE SENT TO ALL PARTIES: Aug/25/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Inpatient stay for two days: L4-S1 laminectomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, 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 medical necessity for inpatient stay for two days: L4-S1 laminectomy is not established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on XX/XX/XX and has been followed for complaints of low back pain and radiating pain to the left lower extremity. Prior treatment had included the use of anti-inflammatories, muscle relaxants, and narcotic analgesics for pain. The patient did attend physical therapy with limited improvement. It is unclear whether the patient actually underwent any injections therapy. Electrodiagnostic studies completed on 05/12/15 were negative for evidence of lumbar radiculopathy. Radiographs of the lumbar spine from 04/15/14 noted some mild disc space narrowing and end plate sclerosis in several levels. MRI studies of the lumbar spine from 06/19/14 noted disc bulging at L4-5 and L5-S1 with facet hypertrophy. There was no clear evidence of canal or foraminal stenosis. CT myelogram studies from 05/13/15 also noted disc bulging at L4-5 and L5-S1 but without any foraminal or central stenosis. The patient had been followed by XXXXXX for continuing low back and left lower extremity pain. The 07/09/15 evaluation noted the patient was unable to tolerate aquatic therapy. The patient's physical exam noted decreased sensation to pin and touch in the L4 through S1 distributions. No focal motor weakness or reflex changes were noted. There was a positive straight leg raise sign to the left at 60 degrees. The requested lumbar laminectomy from L4 through S1 with a 2-day inpatient stay was denied by utilization review on 06/08/15 as there was no evidence of L5 or S1 nerve root compression and electrodiagnostic studies were negative. The request was again denied on 06/18/15 due to the lack of evidence regarding lumbar radiculopathy on imaging or electrodiagnostic studies. It is noted that there was a peer-to-peer conversation between the reviewer and XXXXX. However, no additional information regarding lumbar radiculopathy was provided to support the surgical request.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for persistent low back pain radiating to the left lower extremity which has not improved with medications or physical therapy. There was no documentation regarding a trial of epidural steroid injections which failed to provide any benefit. Epidural steroid injections can be considered as an appropriate non-operative treatment option. The clinical documentation did

note sensory loss in an L4-S1 distribution. However, this did not correlate with any of the diagnostic studies available for review to include MRI and CT studies which found no evidence of stenosis or nerve root contact. There was also no electrodiagnostic evidence for lumbar radiculopathy on the provided studies. Given the insufficient objective evidence to support a diagnosis of L4 through S1 radiculopathy, and as there is no documentation of any complete failure of non-operative management, it is this reviewer's opinion that medical necessity for inpatient stay for two days: L4-S1 laminectomy is not established and the prior denials remain 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)