

IRO NOTICE OF DECISION – WC

DATE OF REVIEW: 03-26-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Request for Lumbar Discogram @ L4-5 with Lumbar Percutaneous Discectomy @ L4-5

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

Certified by the American Board of Orthopaedic Surgery
General Certificate in Orthopaedic 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 or not medical necessity exists for each of the health care services in dispute.

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS/NDC	Upheld Overturn
		Prospective	847.2	62287	Overturn
		Prospective	847.2	62290	Overturn

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Non Certification Of Service/Procedure dated 02-08-07
Result of Reconsideration – Non Certification of Service/Procedure dated 02-21-07
One-page typed Physician Letter if Medical Necessity undated
Physician progress notes dated 10-24-06, 10-31-06, 11-15-06, 12-07-06, and 01-31-07
MRI Lumbar Spine Without Contrast dated 10-31-06
Transmission Reports / Serial Broadcast Reports

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a patient involved in motor vehicle accident en route to work with back symptoms. Physician examination on 10-24-06 documents straight leg raise positive on the right side. Patient reports x-ray of his cervical spine and a CT scan of head and cervical spine following accident were negative. MRI lumbar spine on 10-31-06 showed broad-based disc herniation at L4/L5 in contact with L5 nerve. Patient apparently had some initial effect from epidural steroid injection on 12-01-06 but noted no long-term response from 2 epidural steroids. His treating physician requests lumbar discogram and plasma disc decompression.

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

I believe the procedures requested – percutaneous discectomy with lumbar discogram – are appropriate treatment alternative for this patient. The conservative treatment (i.e., physical therapy, oral / injectable steroids with no long-term response) and work-up has all been appropriate. The patient's presentation is similar and would meet criteria and inclusion for minimally invasive surgery that have shown effectiveness according to these trials. In addition, the currently available literature on this area is not likely to include randomized clinical trials in the future.

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)**