
DATE OF REVIEW: 03/14/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left L5-S1 microdiscectomy

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

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)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An Employer's First Report of Injury or Illness form dated
Evaluations with, D.O. dated xx/xx/xx, 05/31/06, 06/05/06, 06/07/06, 06/12/06,
06/19/06, 06/21/06, 06/27/06, 07/06/06, 07/12/06, and 01/22/07
Physical therapy with, P.T. dated 06/12/06, 06/20/06, 06/21/06, 06/27/06,
06/28/06, 06/30/06, 07/13/06, 07/17/06, 07/19/06, 07/21/06, and 07/24/06
A progress report from Mr. dated 06/27/06
X-rays and an MRI of the lumbar spine interpreted by, M.D. dated 07/07/06
Evaluations with, M.D. dated 07/18/06 and 09/11/06
A TWCC-73 form filed by Dr. dated 07/26/06
Evaluations with, P.A. for Dr. i dated 08/01/06, 08/29/06, 09/26/06, 10/31/06,
11/14/06, 12/12/06, 01/09/07, and 02/06/07
X-rays of the lumbosacral spine interpreted by, M.D. dated 08/02/06

An EMG/NCV study interpreted by, M.D. dated 08/11/06
Procedure notes from Dr. dated 08/29/06, 09/14/06, 09/26/06, and 10/12/06
Evaluations with, P.A.-C. dated 08/30/06, 09/18/06, 10/02/06, 10/16/06,
11/02/06, 11/14/06, 11/28/06, and 01/02/07
An intraoperative fluoroscopy interpreted by, M.D. dated 10/12/06
Evaluations with, M.D. dated 11/27/06 and 01/12/07
X-rays of the lumbar spine interpreted by Dr. dated 11/27/06
A Functional Capacity Evaluation (FCE) with, P.T. dated 12/07/06
A Superbill/Routing Slip from, L.P. dated 12/12/06
A Required Medical Evaluation (RME) with, M.D. dated 12/15/06
A lumbar myelogram and post myelogram CT scan interpreted by M.D. dated
12/29/06
Letters of adverse determination from, dated 01/23/07 and 01/30/07

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx, Dr. recommended OMT, Motrin, Flexeril, and Nexium. Physical therapy was performed with Mr. from 06/12/06 through 07/24/06 for a total of 11 sessions. On 06/27/06, Dr. performed injections of Marcaine, Kenalog, and Toradol. On 06/27/06, Mr. recommended continued physical therapy. An MRI of the lumbar spine interpreted by Dr. on 07/07/06 revealed a mild disc bulge at L5-S1. On 07/18/06, Dr. recommended off work status, an EMG/NCV study, Ultracet, Neurontin, Zanaflex, and Mobic. X-rays of the lumbo sacral spin entered by Dr. on 08/02/06 were normal. An EMG/NCV study interpreted by Dr. on 08/11/06 revealed mild left S1 radiculopathy and borderline changes on the right. Dr. performed lumbosacral transforaminal epidural steroid injections (ESIs) on 08/29/06, 09/14/06, 09/26/06, and 10/12/06. On 10/31/06, Ms. prescribed Pamelor. On 11/27/06 and 01/12/07, Dr. recommended lumbar surgery. An FCE with Ms. on 12/07/06 indicated the patient functioned at a sedentary-light physical demand level. On 12/15/06, Dr. recommended a myelogram CT followed by possible surgery. A lumbar myelogram CT scan interpreted by Dr. revealed mild disc bulge at L5-S1. On 01/23/07 and 01/30/07, wrote letters of adverse determination for the lumbar surgery. On 02/06/07, Ms. refilled the Duragesic patches.

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

Both the MRI and the CT myelogram show a slight bulge without any significant narrowing of the neural foramen. The CT myelogram, which is far more exact than the MRI scan, shows no evidence of disc herniation or nerve root compression. M.D. has shown that the results of surgery are directly proportional to the amount of nerve root compression. Given the minimal compression noted on the CT myelogram on 12/29/06, the results of surgery would not be expected to be beneficial. Therefore, I would not recommend surgery. In my opinion, the requested left L5-S1 microdiscectomy is not reasonable or necessary as related

to the original injury as there is insufficient pathology to justify surgical intervention.

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 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)

M.D. has shown that the results of surgery are directly proportional to the amount of nerve root compression.