

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 29, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left L5-S1 Lumbar posterior extradural exploration for possible lysis of adhesions and removal scar tissue, 1 day inpatient stay, PT: 63042, 99222

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

MD, Board Certified Orthopedic Surgeon

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.

The reviewer finds that medical necessity does not exist for Left L5-S1 Lumbar posterior extradural exploration for possible lysis of adhesions and removal scar tissue, 1 day inpatient stay, PT: 63042, 99222.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 11/4/08, 11/12/08
Guidelines and Treatment Guidelines
, MD, 10/28/08, 5/23/08, 8/7/08, 7/8/08
, MD, 10/4/07
Exams, 9/12/07, 8/28/07, 6/27/08, 5/28/08, 7/17/07, 7/10/07
MRI Lumbar Spine, 8/17/07, 5/1/08
Personal Medical History, 5/23/08
Spine Lumber 1-View, 1/15/08, 8/7/08
Operative Reports, 1/15/08, 8/7/08
, MD, 6/21/08
Chest 2 Views, 8/5/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx-year-old male who has undergone previous surgery in the form of an L5-S1 hemilaminectomy and partial discectomy on 1/5/08. The patient apparently underwent the procedure without difficulty according to the operative report. He was injured on xx/xx/xx. An MRI from 5/1/08 reveals post operative changes with prior left hemilaminectomy, some disc bulging and enhancing scar tissue which appears to have caused some mass effect on the left side of the canal. There was no significant stenosis noted elsewhere. The patient has continuing complaints of pain on the left posterior thigh and some pain on the bottom of his left foot. There is global subjective weakness of the left lower extremity. He had a Medrol DosePak which did not make him better. In fact, the patient said it made him worse. The patient feels he is worse off now than he was prior to the surgery. He is said to have a severe antalgic gait and weakness of the left plantar flexion. The current request is for Left L5-S1 Lumbar posterior extradural exploration for possible lysis of adhesions and removal scar tissue, 1 day inpatient stay.

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

According to the ODG Guidelines, this type of procedure is not recommended due to lack of significant literature support. The medical records reviewed in this case have not provided any reason why the guidelines should not be followed in this particular case. The reviewer finds that medical necessity does not exist for Left L5-S1 Lumbar posterior extradural exploration for possible lysis of adhesions and removal scar tissue, 1 day inpatient stay, PT: 63042, 99222.

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 KNOWLEDGBASE
- AHCP- 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)**