



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 2/21/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a right lumbar microdiskectomy at L4-L5 w/ LOS 1 day.

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

The reviewing physician is a Medical Doctor who is board certified in Orthopedic Surgery and has been practicing for greater than 15 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a right lumbar microdiskectomy at L4-L5 w/ LOS 1 day.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: the carrier, Dr. and from the patient.

These records consist of the following: (duplicate records are only listed from one source): carrier: 2/6/08 letter, 1/7/08 report by, MD, 8/30/07 report MD with DWC 69, 8/30/07 report FCE, 12/17/07 RME, MD, various DWC 73's, 11/7/07 to 12/19/07 reports, DO, 11/30/07 nerve block report, 12/18/07 to 12/28/07 notes, MD, 12/28/07 radiology report, E1 and 2/6/08 PLN11.

Dr. : FCE 7/24/07,1/2/07 to 12/28/07 notes, MD, and lumbar MRI 6/2/07.

URA: 1/2/08 note, MD.

Patient: 1/15/08 letter, MD, 2/4/08 letter, MD.

We did not receive the WC Network Treatment Guidelines from Carrier/URA. However, we did receive a copy of the ODG.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with back and right leg pain extending to the toes following lifting injury at work. He has undergone physical therapy, used NSAIDs, and has had a positive nerve root block at L45 on the right all without relief. MRI reveals right L45 disc herniation with foraminal stenosis.

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

ODG cite for 722.10 lumbar disc displacement w/o myelopathy:

ODG Indications for Surgery -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. (Andersson, 2000) Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

- A. L3 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral quadriceps weakness/mild atrophy
 - 2. Mild-to-moderate unilateral quadriceps weakness
 - 3. Unilateral hip/thigh/knee pain
- B. L4 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
 - 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
 - 3. Unilateral hip/thigh/knee/medial pain
- C. L5 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
 - 2. Mild-to-moderate foot/toe/dorsiflexor weakness
 - 3. Unilateral hip/lateral thigh/knee pain
- D. S1 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy

2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
3. Unilateral buttock/posterior thigh/calf pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

1. MR imaging
2. CT scanning
3. Myelography
4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following:

A. Activity modification (not bed rest) after patient education (\geq 2 months)

B. Drug therapy, requiring at least ONE of the following:

1. NSAID drug therapy
2. Other analgesic therapy
3. Muscle relaxants
4. Epidural Steroid Injection (ESI)

C. Support provider referral, requiring at least ONE of the following (in order of priority):

1. Physical therapy (teach home exercise/stretching)
2. Manual therapy (massage therapist or chiropractor)
3. Psychological screening that could affect surgical outcome
4. Back school (Fisher, 2004)

The proposed treatment is medically necessary due to the fact that the patient exhibits L5 nerve root compression, positive nerve root tension (straight leg raising), and unilateral pain to the toes on the right (satisfying I.C.3.). He has a positive MRI with nerve root compression at L4/5 on the right compatible with his symptoms (satisfying II.A.1.). He has had a fully adequate trial of conservative therapy, including modifying his activity for >2 months, NSAID treatment and physical therapy (satisfying III. A, B, and C).

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)**