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Notice of Independent Review Decision

DATE OF REVIEW: 02-13-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Microdiskectomy L5-S1 with 1 day LOS

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

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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	847.2	63030	Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Determination Letters 11-27-07 and 12-11-07
Preauthorization request 1-23-08, 12-3-07

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Physician/Practitioner Progress Notes 7-3-07, 7-25-07, 8-6-07, 8-8-07, 8-24-07,
9-13-07, 11-1-07, 11-8-07, 11-14-07, 11-21-07, 11-28-07, 1-9-08

Letter 10-1-07

Addendum 12-3-07

Radiology Report 7-20-07

Electrodiagnostic Study 11-26-07

Procedure note 8-16-07

Official Disability Guidelines (ODG): Indications for Surgery-
Discectomy/laminectomy

PATIENT CLINICAL HISTORY:

This claimant was noted to have low back pain and evaluation noted status post herniated nucleus pulposus (HNP) of the lumbar spine. The physical examination noted positive straight leg raising and plain films were noted with no pathology being identified. An MRI was completed noting a HNP (7mm) at L5-S1 with nerve root encroachment and indications of acute lesion. The August evaluation noted no improvement. Epidural steroid injection was performed on 8-16-07, and the claimant realized an 80% reduction in pain complaints. However, there were reported residual low back and leg pains. EMG noted bilateral L5 radiculopathies.

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

As noted in the Official Disability Guidelines, the indications for a lumbar surgery include “carefully selected patients with radiculopathy due to lumbar disc prolapse” and “Unequivocal objective findings are required based on neurological examination and testing. (Gibson-Cochrane, 2000) (Malter, 1996) (Stevens, 1997) (Stevenson, 1995) (BlueCross BlueShield, 2002) (Buttermann, 2004). Standard discectomy and microdiscectomy are of similar efficacy in treatment of herniated disc (Bigos, 1999). There is objectification of the disc lesion (in this case a positive MRI {Indication II.C.1}) significant changes on physical examination (weakness to dorsiflexion {Indication I.C.1.}) straight leg raising and failure of conservative care/medicines (Indication III. B.1 & 4). Therefore, it is the Reviewer’s opinion that the surgery is indicated and could be done in a 23-hour stay.

**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)