

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 06/18/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient lumbar microdiscectomy L4-L5

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

The TMF physician reviewer is a board certified neurosurgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the inpatient lumbar microdiscectomy L4-L5 is not medically indicated to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Letter to TMF– 06/12/08
- Determination letter– 05/06/08, 05/27/08
- Letter from Dr to Dr.– 04/29/08, 05/15/08, 06/03/08
- Designated Doctor Evaluation by Dr. – 04/08/08

- Orthopedic clinic notes by Dr. – 12/11/07
- Office visit notes by Dr. – 12/03/07
- Office visit notes from Medical Care – 07/19/07 to 08/22/07
- Report of MRI of the lumbar spine – 08/11/07
- Pre-Authorization Request Form – 06/05/08
- Request for Review by an IRO – 06/03/08
- Information from TDI to TMF requesting a review by an IRO – 06/09/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury when he was working as a , a door latch broke and he fell out while driving and sustained injuries to his lower back. The patient was diagnosed with sciatica with herniated disk at L4-L5. An MRI of the lumbar spine revealed left paracentral disc protrusion/herniation at the L4-5 level. The patient has been treated with conservative care including physical therapy and epidural steroid injections.

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

The proposed surgical procedure could be indicated because it appears that the patient has appropriate symptoms consistent with herniated nucleus pulposus at L4-L5 that have failed satisfactory conservative care. However, the MRI report of 08/11/07 fails to indicate the presence of nerve root compromise. Unless the MRI is re-read or a new scan is performed that addresses the presence or absence of this issue, then the surgery as planned is not medically indicated.

**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)