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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/15/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar microdiscectomy L4-L5 with annular repair and implant of prosthetic device

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Adverse Determination Letters, 03/06/09, 03/12/09

Office note, Dr. 11/05/07

Office notes, Dr. 2007, 01/02/08, 01/31/08, 02/27/08, 03/26/08, 04/28/08, 08/15/08, 09/24/08, 10/22/08, 10/31/08, 02/18/09

Office note, Dr. 11/08/07

Office notes, Dr. 11/27/07, 01/08/08, 02/12/08, 03/11/08, 04/15/08 05/13/08

Office notes, Dr. 03/14/08, 04/08/08

Office note, Dr. 05/19/08

Office notes, Dr. 06/23/08, 07/07/08, 08/04/08, 09/08/08, 09/22/08

Office note, Dr. 07/11/08

Office notes, Dr. 10/30/08, 11/26/08, 12/23/08

Office note, Dr. 03/19/08

Procedure, 12/13/07, 01/24/08

MRI lumbar spine, 11/06/07, 04/01/08

EMG, 12/03/08

Work status report, 07/11/08

Functional capacity evaluation, 02/08/08, 05/08/08

Emergency Department record, xx/xx/xx

Employer First Report of injury or illness
Independent Review Summary, 03/31/09
Computerized Muscle Testing, 02/18/09
Chronic Pain Recovery Records, 2008
Range of motion – inclinometry, 11/16/07, 12/21/07, 01/02/08, 01/31/08, 03/26/08
Associate statement, 11/07/07
Physical therapy records, 2007, 2008
MD Rx 08/18/08, 11/05/08
Investigation Report, 05/09/08, 05/22/08, 05/23/08

PATIENT CLINICAL HISTORY SUMMARY

This is a female claimant with a history of low back pain and leg pain since a reported repetitive lifting injury of xx/xx/xx. The records indicated that the claimant had 11/06/07 MRI findings of a significant left L4-5 disc extrusion with severe left L5 nerve compression. An EMG / NCS performed on 12/03/07 showed left L4 and L5 radiculopathy. The claimant was diagnosed with lumbar nucleus pulposus and lumbar discogenic pain with left lower extremity radiculopathy. Conservative treatment included medications, physical therapy, two lumbar epidural steroid injections with eighty percent decrease in pain.

Worsening low back and leg pain was noted in March 2008. A lumbar MRI followed on 04/01/08 which showed mild degenerative disc disease L4-5 with a protrusion that impressed upon the left thecal sac. There was minimal acquired central canal stenosis. There was also moderate bilateral facet arthropathy L5- S1. The treating physician noted the most recent MRI looked much better than the previous one. The large disc extrusion left L4-5 had reabsorbed for the most part with a small disc protrusion at L5- S1.

The claimant continued to treat conservatively for back pain and minimal leg pain. A physician record dated 10/31/08 noted that the claimant has completed six weeks of a chronic pain management program and was working full duty. A 02/18/09 physician record revealed the claimant with back pain with radiation down the left lower extremity associated with numbness and cramping in the left leg. A lumbar laminotomy and microdiscectomy L4-5 was recommended.

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

The requested L4-5 microdiscectomy with annular repair and implant of prosthetic device cannot be justified as medical necessary based on the information provided.

The claimant's most recent MRI of 04/01/08 was reported to show improvement with resorption of a previous disc extrusion. Dr. noted only a small left protrusion just contacting the L5 nerve root. Later records indicated inconsistent reports of leg pain, and records do not indicate a focal dermatomal pattern. There is no objective physical exam data to correspond with the imaging findings. The most recent EMG of 12/03/08 does not correspond with the prior MRI. The rationale for implanting "interbody mesh" remains unclear and is not standard for the surgery being performed. Given the discrepancy between the most recent electrodiagnostic studies and the previous MRI, repeat MRI with contrast may be warranted. The last MRI is nearly one and one half years old. It is inconsistent with the electrodiagnostic study results. The request for Lumbar microdiscectomy L4-L5 with annular repair and implant of prosthetic device does not meet the ODG. For all these reasons, the requested surgery cannot be justified at this time based on the information reviewed. The reviewer finds that medical necessity does not exist for Lumbar microdiscectomy L4-L5 with annular repair and implant of prosthetic device.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

- ACOEM-AMERICA 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)