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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 08/12/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar microdiscectomy at L4-L5

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

Board Certified in Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X 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.

Lumbar microdiscectomy at L4-L5 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY

A lumbar myelogram CT scan interpreted by Dr. on 07/31/07 revealed mild to moderate disc bulging at L4-L5 with mild disc space narrowing. An EMG/NCV study interpreted by Dr. on 08/27/07 revealed left greater than right L5 greater than S1 lumbar radiculopathy and evidence of sensory greater than motor peripheral neuropathy, most likely due to a metabolic process such as diabetes mellitus. An MRI of the lumbar spine interpreted by Dr. on 12/17/07 revealed disc pathology at L2 through L5 with partial sacralization of the L5 segment with a somewhat rudimentary L5-S1 disc space. On 05/06/08, Dr. recommended lumbar spine surgery. On 05/22/08, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 5% whole person impairment rating. On 02/20/09, Dr. recommended a lumbar discogram CT scan. On 06/29/09, Dr. recommended a lumbar laminotomy with microdiscectomy at L4-L5. On 07/07/09, Dr. wrote a letter of non-certification for the lumbar surgery. On 07/22/09, Dr. also wrote a letter of non-certification for the lumbar surgery.

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

The ODG criteria for a laminectomy/discectomy are very specific. The patient must demonstrate a very specific set of symptoms that are then verified by anatomy discerned by MRI or CT myelogram and can be confirmed by electrodiagnostics. This particular constellation of symptoms evidenced by the patient did not rise to the level of radiculopathy. The EMG demonstrates multiple areas of electric disturbance, consistent not with radiculopathy, but with a false/positive examination. The patient does have evidence of a very significant sensory neuropathy, felt to be secondary to a metabolic process. Neutral examiners have not demonstrated any neurological abnormality. Dr. has demonstrated L5 weakness, but this has not been noted by any other examiners. The Designated Doctor, for example, documented a normal neurological examination in what was documented to be a thorough examination.

The CT myelogram did not demonstrate significant neural narrowing. It is my opinion that the patient does not have significant narrowing of the neural foramen. When comparing results of the CT myelogram versus the later MRI, one must understand that an MRI is sometimes an "overread", that is there is more compression demonstrated on the MRI than is later seen on a CT myelogram. If the two studies disagree, the CT myelogram is more exact. There is no evidence of neural compression. The patient is now two years after injury. The best timeframe for decompression is within six months to a year. Based on the constellation of findings, it is unlikely that the patient would improve with a decompressive laminectomy. Therefore, using evidenced based medicine, based on the ODG and current medical literature, the requested lumbar microdiscectomy at L4-L5 would be neither reasonable nor necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE**
- ☐ **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**

X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X **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)**

X **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**