



Notice of Independent Review Decision

**IRO REVIEWER REPORT**

**DATE OF REVIEW:** 8/28/09

**IRO CASE #:**                      **NAME:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Determine the appropriateness of the previously denied request for right L5-S1 microdiscectomy/decompression/tissue repair with CPT codes 63030, 22899, 69990, 76000 (denied on 7/10/08).

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

Texas Licensed Neurological 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)

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.

The previously denied request for right L5-S1 microdiscectomy/decompression/tissue repair with CPT codes 63030, 22899, 69990, 76000 (denied on 7/10/08).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Follow Up dated 5/18/09.
- Texas Workers' Compensation Work Status Report dated 7/27/09, 6/10/09, 5/22/09, 4/30/09, 3/25/09, 2/18/09, 2/12/09, 2/5/09, 11/24/08, 11/17/08, 11/10/08, 11/03/08
- Encounter Notes dated 7/27/09, 5/22/09, 4/30/09, 3/25/09, 2/12/09, 2/5/09, 11/24/08, 11/17/08, 11/10/08, 11/3/08.
- Physical Therapy Progress Report dated 1/28/09, 1/21/09, 1/19/09, 1/14/09, 1/12/09, 1/7/09, 12/1/08.
- Physical Therapy Referral & Consultation dated 11/10/08.
- Neurosurgical Follow-Up dated 5/15/09.
- Notification Letter dated 4/21/09.
- Lumbar Spine Ct dated 5/14/09, 5/14/09.
- Final Report dated 5/14/09.
- Lumbar Spine MRI dated 2/9/09.
- Referral Information dated 6/18/09.
- Patient Information dated 7/24/09, 5/22/09.
- History or Present Illness dated 6/10/09.
- Appeal Letter dated 7/20/09.
- Notification of Determination dated 7/10/09.
- Reconsideration Letter dated 7/29/09.
- Carrier Submission dated 8/24/09.
- Fax Cover Sheet dated 8/17/09.

**PATIENT CLINICAL HISTORY (SUMMARY):**

Age: xx Years Old  
 Gender: xxxx  
 Date of Injury: xx/xx/xx  
 Mechanism of Injury: Putting pins in a spreader.

Diagnosis: Lumbar radiculitis and herniated disc

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

This xx year-old male has a date of injury of xx/xx/xx. The claimant was injured while putting pins in a spreader. He complained of back and left buttock pain, diagnosed as lumbar radiculitis and herniated disc. He had been treated with physical therapy, medications, and epidural steroid injections (ESI). A neurological examination on 6/10/09 was normal. An MRI of the lumbar spine, dated 2/9/09, revealed multilevel disc protrusions, with broad-based disc bulge at L5-S1, producing mild effacement of the anterior subarachnoid space; however, there was no impingement of nerve roots and no significant narrowing of the lateral recesses. There was minimal narrowing of the neuroforamina, left greater than right. A CT of the lumbar spine, dated 5/14/09, showed moderate spinal narrowing and bilateral recess narrowing, moderate in severity. At L4-5 there was mild bilateral recess narrowing. Plain films of the lumbar spine report, dated 5/14/09, revealed multilevel instability with retrolisthesis essentially at each level

throughout. The provider is requesting a right L5-S1 microdiscectomy/decompression/tissue repair 63030 22899 69990 76000. The surgery is not medically necessary. According to the ODG, "Low Back" chapter, section on discectomy, radiologic evaluation should indicate "one nerve root compression, lateral disc rupture, or lateral recess stenosis." This was not demonstrated on the imaging studies. Moreover, there was a paucity of findings on the examination to suggest that the claimant was experiencing an S1 radiculopathy and would be relieved by an L5-S1 discectomy. He, in fact, appeared to complain primarily of back pain. Therefore, the surgery is not medically necessary, based on the ODG criteria for surgery.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.  
**Low Back Chapter, section on discectomy.**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).