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Notice of Independent Review Decision

AMENDED REPORT 8/19/2009

DATE OF REVIEW: 8/19/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a right L5-S1 discectomy with inpatient LOS x 2 (63042, 63044).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years in this specialty and performs this type of procedure in his office.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a right L5-S1 discectomy with inpatient LOS x 2 (63042, 63044).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Insurance Company
Neurosurgical Associates –MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed by Insurance Company: list of service providers,

Denial letter – 7/20/09 & 7/27/09; Health System MRI report – 3/1/07; Medical Center Operative Report – 6/12/07; Health System Operative Report – 5/29/09; MD Office Note – 7/7/09 & 7/13/09; ODG Low Back – Lumbar & Thoracic chapter.

Records reviewed by Neurosurgical Associates –MD: MD letter – 11/10/08, Encounter Summary – 4/7/09-7/13/09, Admission notes – 5/29/09, Operative Report – 5/29/09; MD MRI report – 5/5/09; Health Systems Sinus Rhythm report – 5/26/09, Patient Client Reports – 5/26/09-5/27/09; S Porter, MD x-ray report – 5/29/09; MD MRI Report – 7/13/09

A copy of the ODG was provided by the Carrier for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx year old male who injured his low back at work. He underwent a laminectomy and discectomy at L5-S1 on the right for HNP on xx/xx/xx. Postoperatively, he has developed a recurrent HNP at L5-S1 on the right as shown on an MRI on 7/13/09 with noted fluid collections in the paraspinous musculature and subcutaneous tissue at the operative site.

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

This patient represents a reherniation less than 6 weeks postoperatively from a previous surgery. It would be unreasonable to repeat conservative care which has already been completed prior to his primary procedure as conservative care at this point has proven to be unsuccessful and would fail given the irritated nature of the lumbar spine and fluid collections compatible with hematoma in the epidural space and paraspinal musculature at latest MRI. THE ODG does not address recurrent HNP in the acute postoperative period.

According to the ODG: Microdiscectomy for symptomatic lumbar disc herniations in patients with a preponderance of leg pain who have failed nonoperative treatment demonstrated a high success rate based on validated outcome measures (80% decrease in VAS leg pain score of greater than 2 points), patient satisfaction (85%), and return to work (84%). Patients should be encouraged to return to their preinjury activities as soon as possible with no restrictions at 6 weeks. This gentleman meets the criteria; therefore, this procedure should be approved at this point according to the records provided.

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)**