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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left L4-5 microdiscectomy, L3-4 bilateral foraminotomies with 2 days inpatient stay (63047, 99222)

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

M.D., board certified in Orthopedic Surgery

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

Adverse Determination Letters, 7/1/09, 5/28/09

MD, 12/3/08, 1/4/09, 2/4/09, 2/18/09

Notes, 11/20/08

Radiology Exam Report, 2/16/09

Spine Cervical Myelogram CT, 2/16/09

Bone & Joint Clinic, 3/18/09

MD, 4/16/09, 4/21/09

Dr., 5/12/09, 6/24/09

Notes, 7/1/09

Job Description

ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a xx-year-old male whose injury was reported to be xx/xx/xx. He was moving a generator and hurt his back. He has a history, apparently, of three back surgeries, the last one in 1984. He also has had neck surgery. He has a myelogram with post CT scan showing a large L4/L5 disc herniation and central stenosis at L3/L4. The physical

examination did not reveal any neurological deficit and was normal to heel-toe walk. There was some question of straight leg raising being positive on the left. There was some hypoesthesia in the L5/S1 distribution. There was some asymmetry of the reflexes; however, the motor examination as per the last examinations both by the attending and by an independent reviewer, were normal. There was no evidence of myelopathy, clonus, or other signs of myelopathy noted on the physical examinations nor the diagnoses.

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

Based on the ODG Guidelines for surgery, a L5 nerve root compression would require one of the following: severe unilateral foot/toe dorsiflexion weakness, mild to moderate toe/foot dorsiflexion weakness, unilateral hip, lateral thigh, and knee pain. These are not present in this individual as his motor strength is normal, and he fails to meet these criteria. Based upon the medical records provided, the neurological findings did not reveal any significant motor deficit that would place this patient within the ODG Guidelines. The treating surgeons have not explained why in this case the guidelines should be set aside. Furthermore, though he does have some stenosis at L3/L4, there is no evidence of myelopathy on physical examination nor with symptoms. Hence, the surgery for the central stenosis also falls outside of normally recommended treatment practices. The reviewer finds that medical necessity does not exist for Left L4-5 microdiscectomy, L3-4 bilateral foraminotomies with 2 days inpatient stay (63047, 99222).

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)