



Notice of Independent Review Decision

DATE OF REVIEW: 3/25/09

Date Amended: 4/8/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for lumbar laminectomy/discectomy, foraminotomy and partial facetectomy at L3-4.

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 lumbar laminectomy/discectomy, foraminotomy and partial facetectomy at L3-4.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice of Assignment of Independent Review Organization dated 3/24/09.
- Request for a Review by an Independent Review Organization dated 3/23/09.

- IRO Letter of Medical Necessity dated 3/23/09.
- Prior Authorization Request Sheet dated 3/5/09.
- Follow-Up Note dated 7/14/08, 5/5/08, 2/28/08, 1/10/08, 12/6/07, 12/3/07, 11/7/07, 10/4/07, 8/16/07, 7/25/07, 7/9/07.
- Prescription dated 2/28/08, 1/10/08, 12/6/07, 12/4/07, 8/16/07, 7/25/07, 7/9/07, 6/27/07.
- Prior Authorization Request Sheet dated 2/25/09.
- Fax Cover Sheet/Surgery Appointment note dated 2/19/09.
- Pre-Surgical Behavioral Evaluation dated 2/13/09.
- Follow-Up/Letter dated 1/19/09.
- Consultation Report/Letter dated 9/15/08, 12/3/07.
- Lumbar Myelography/Computed Tomography Procedure Report dated 11/24/08.
- Operative Report dated 6/30/08.
- Progress Note dated 10/22/07, 10/12/07, 10/3/07, 10/5/07, 10/2/07, 9/11/07, 9/7/07, 9/5/07, 8/29/07, 8/27/07, 8/23/07, 8/20/07, 7/11/07, (unspecified date).
- Physical Examination Note dated 6/22/07.
- MRI of Lumbar spine Report dated 4/30/07.
- Patient Information Sheet (unspecified date).

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: Bent down to lift a shovel.

Diagnosis: Degenerative Disc Disease

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

This is a male with a date of injury xx/xx/xx, when he was bending down to lift a shovel. He initially had pain on the right, but this has now resolved with conservative measures, and he remained with pain in the left leg. He has had physical therapy and epidural steroid injections (ESI's). Neurological examination revealed hypesthesia in the L4 distribution on the left. There was a decreased knee jerk on the left. There was weakness in the left quadriceps. An MRI of the lumbar spine on 04/30/2007 revealed a left foraminal disc herniation compressing the exiting left L3 nerve root. A lumbar myelogram/CT 11/24/2008, revealed mild central stenosis at L3-L4. There was no mention of any nerve root compression. At L5-S1, there was a prominent deformity on the right, extradural. A presurgical behavioral evaluation 3/11/2009, cleared the patient for surgery. The provider is recommending a lumbar laminectomy/discectomy, and partial facetectomy at L3-L4. The surgery is not medically necessary, based on the

submitted documentation. The MRI demonstrating the herniated disc is nearly two years old. A recent CT myelogram made no mention of this disc and reported only mild central stenosis at L3-L4. The provider state in his clinic note that this study (the CT myelogram) showed severe foraminal stenosis at L3-L4 on the left, but this was not consistent with the enclosed radiology report. It is known that herniated discs can resolve/resorb over time. It is true that, even though there is a large herniated disc to the right at L5-S1, the patient appears to be asymptomatic from this. However, according to the ODG, "Low Back", indications for discectomy state imaging studies should show concordance between radicular findings on radiologic evaluation and physical exam findings. This is not the case with the most recent study, and therefore, the procedure is not medically necessary.

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.
- Official Disability Guidelines (ODG), Treatment Index, 7th Edition (web), 2009, Low back—Laminectomy/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).