



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 10/19/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of outpatient right lumbar decompression microendoscopic at L4-5 (63047 & 69990).

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 agrees with the previous adverse determination regarding the prospective medical necessity of outpatient right lumbar decompression microendoscopic at L4-5 (63047 & 69990).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

Insurance Company
MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from : Denial letter – 8/6/09 & 8/20/09; FNP Office Notes – 8/26/08-9/15/09; MD Cat Scan report – 8/28/08; MD Office notes – 9/24/08; MD MRI Report – 10/13/08; MD Office Notes – 12/3/08-5/4/09; DC EMG/NCV report – 6/12/09; MD Office Notes – 7/9/09; ODG Discectomy/Laminectomy chapter.

Records reviewed from MD: Office Notes – 10/17/08-7/29/09; MRI Report – 10/13/08.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male. He underwent an interbody fusion with cages at L3-4 in 1998. He injured his back lifting a patient at work on xx/xx/xx. A CT scan on 8/28/08 noted mild to moderate stenosis at L4-5 and recommended an MRI to better evaluate soft tissues. The MRI on 10/13/08 read as L3-4 postsurgical changes but no other level significant disc bulge or stenosis identified.

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

The records reflect an MRI that states there is no compressive lesion at the proposed surgical level, and a CT that defers to MRI after saying there is probable moderate stenosis. The EMG/NCV is diagnostic for levels other than the proposed surgical level. The only diagnostic certainty at L4-5 is a positive nerve root block, but no compressive lesion has been documented. The stenosis that may exist is not compatible with an acute onset event without a herniation which is not visualized.

According to the ODG: Indications for Surgery -- Discectomy/laminectomy -- Required symptoms/findings; imaging studies. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

- 1. MR imaging
- 2. CT scanning
- 3. Myelography
- 4. CT myelography & X-Ray

The patient does not meet the criterion set forth by the ODG; therefore this 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 & 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)**