



DATE OF REVIEW: 09/17/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Lumbar surgery, L5/S1 far lateral discectomy

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering spine problems

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. ZRC forms
2. TDI referral forms
3. Denial letters dated 08/07/09 and 08/25/09
4. Requestor records
5. Clinical records, 08/18/09, 07/21/09, 07/07/09
6. EMG/nerve conduction study, 07/21/09
7. URA records including precertification request, 08/04/09
8. MRI scan, 05/19/09

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is a male with a muscular straining injury while working on a truck attempting to manipulate a chain. He suffered low back pain with pain radiating into his left lower extremity. He has been evaluated on a number of occasions. Straight leg raising test is positive. There is a suggestion of sensory dysesthesia and muscular weakness in the left foot. The initial evaluation resulted in multiple diagnoses of strain including lumbar, cervical, and right shoulder. The EMG/EMG study suggests L5

radiculopathy on the left side, and the MRI scan suggests degenerative disc disease at L4/L5 and L5/S1. There is no documentation of specific nonoperative treatment. There is no documentation of physical therapy or epidural steroid injections.

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

There is no documentation of nonoperative treatment. There is no documentation of physical therapy or epidural steroid injection. In the absence of any specific nonoperative treatment other than pain medication, discectomy is not recommended. The ODG 2009 Low Back Chapter Discectomy/Laminectomy passage criteria have not been met.

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

(Check any of the following that were used in the course of your review.)

- 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)