

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION -- AMENDMENT

Date of Notice of Decision: Nov/30/2010

Date of Notice of Amended Decision: December 7, 2010

DATE OF REVIEW:

Nov/29/2010

DATE OF AMENDED REVIEW: December 7, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient 23 hour observation for lumbar microdiscectomy at L3-4 and L4-5

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

MD, Board Certified Neurosurgeon

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

Risk Management Fund 10/20/10, 11/3/10

MD 11/12/10

IRO Review 2/16/10

7/25/05

Diagnostic 9/23/10

Neurodiagnostic Associates 12/21/05

EMG/NCS 10/24/08

MD 10/24/08

Therapy & Diagnostic 1/25/10

Hospital - 6/7/06

BHI 2 11/29/07

Microsurgical Anular Reconstruction article no date

Orthopedics 10/23/09 to 1/25/10

ODG Indications for Surgery -- Discectomy/laminectomy

PATIENT CLINICAL HISTORY SUMMARY

This is a female with a date of injury xx/xx/xx, when she tripped and fell off of a stage. She has undergone physical therapy, ESIs, and medications. Electrodiagnostic studies 10/24/2008 showed no evidence of bilateral lumbar radiculopathy. A clinic note 10/23/2009 states that she has parasthesias and decreased sensation in the left L4 distribution and weakness in the left quadriceps. There is a diminished left patellar reflex. This is also noted on 01/25/2010, 04/19/2010 and 07/12/2010. The clinic note from 09/10/2010 states that she has weakened left quadriceps strength. An MRI 09/23/2010 shows a previously noted left L3-L4 protrusion with left foraminal encroachment in addition to a new left L4-L5 protrusion with moderate foraminal encroachment. There is also a subtle grade I spondylolisthesis at L3-L4. The provider is requesting inpatient 23 hour observation for lumbar microdiscectomy at L3-4 and L4-5

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

Inpatient 23 hour observation for lumbar microdiscectomy at L3-4 and L4-5 is medically necessary. The patient has failed reasonable conservative measures for her pain. She has objective evidence of L3-L4 left radiculopathy, with findings on examination that correlate with the neuroimaging. There is neuroforaminal encroachment on the left both at L3-L4 and L4-L5. The surgery is, therefore, medically necessary, and consistent with ODG criteria for lumbar discectomy, as listed below. Inpatient status (one-day) or observation status for this procedure are both commonly done and medically necessary. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned.

ODG Indications for Surgery| -- Discectomy/laminectomy -

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. (Andersson, 2000) Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging

Findings require ONE of the following

A. L3 nerve root compression, requiring ONE of the following

1. Severe unilateral quadriceps weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps weakness
3. Unilateral hip/thigh/knee pain

B. L4 nerve root compression, requiring ONE of the following

1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
3. Unilateral hip/thigh/knee/medial pain

C. L5 nerve root compression, requiring ONE of the following

1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
2. Mild-to-moderate foot/toe/dorsiflexor weakness
3. Unilateral hip/lateral thigh/knee pain

D. S1 nerve root compression, requiring ONE of the following

1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
3. Unilateral buttock/posterior thigh/calf pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. 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

III. Conservative Treatments, requiring ALL of the following

A. Activity modification (not bed rest) after patient education (\geq 2 months)

B. Drug therapy, requiring at least ONE of the following

1. NSAID drug therapy
2. Other analgesic therapy
3. Muscle relaxants
4. Epidural Steroid Injection (ESI)

C. Support provider referral, requiring at least ONE of the following (in order of priority)

1. Physical therapy (teach home exercise/stretching)
2. Manual therapy (chiropractor or massage therapist)
3. Psychological screening that could affect surgical outcome
4. Back school (Fisher, 2004)

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)