

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/01/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

T10/11 Microdiscectomy (63030, 36000, 99217, 99144)

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

M.D., Board Certified Orthopedic Surgeon  
Board Certified Spine 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

CMS, 4/12/10, 4/28/10

Neuroscience & Spine Center, P.A. 3/22/10, 3/28/05, 4/7/10,  
4/2/10

Healthcare System 2/20/10, 2/14/10, 3/31/10

M.D. 1/24/05, 1/10/05

M.D. 11/8/04, 11/19/04, 11/30/04, 12/6/04, 2/7/05

Open Air MRI 2/25/10

Imaging Center 1/17/05, 12/2/04

M.D. 1/17/05

Solutions 4/23/10

ODG-TWC

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker who, according to history, injured his back while lifting a heavy bag, resulting in back pain and radiculopathy. A T10 lesion appears to have been identified, both on MRI scan and myelography. On the CT myelogram it is noted that the T10/T11 level, there is a left lateral recess soft tissue mass which impinges upon the thecal sac. It does not displace the cord. It is noted that the tissue is contiguous with the disc space and consistent with a disc herniation with superior extrusion of the disc. Current request is for T10/11 Microdiscectomy (63030, 36000, 99217, 99144).

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

The Official Disability Guidelines and Treatment Guidelines do not specifically address thoracic disc lesions. There are significant differences in the management of blastic and lumbar disc lesions, however, and given the time since the injury, the consistent findings on imaging studies and the radicular complaints, it is this reviewer's opinion that the requesting surgeon has satisfied generally acceptable clinical criteria and that the previous adverse determination should be overturned. The reviewer finds that medical necessity exists for T10/11 Microdiscectomy (63030, 36000, 99217, 99144).

**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)  
OKU Spine

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)