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Notice of Independent Review Decision

DATE OF REVIEW: 3/3/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under review include the medical necessity of a lumbar diskectomy at L4/5 (outpatient) (63047).

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 and has been practicing for greater than 15 years.

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 medical necessity of a lumbar diskectomy at L4/5 (outpatient) (63047).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Dr., and MD.

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from: precert request 12/9/09, 12/1/09 Hx and physical report, 11/10/09 lumbar MRI report, 11/30/09 lumbar MRI report w/ contrast, 9/11/09 report by, MD, 1/5/10 report by Dr. and 12/14/09 denial letter.

Dr.: 1/5/10 addendum note, 12/9/09 addendum note, pt referrals 9/21/09, 10/26/09 and 11/23/09, various DWC 73 forms and 1/13/10 denial letter.

Dr.: all records were duplicate of those listed above.

We did not receive the WC Network Treatment Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was noted by Dr. (on 12 1 09) to have back pain with occasional left leg radiation and numbness, post slip and fall while working. Dr. stated that the claimant indicated that he was “not currently experiencing much leg pain.” The AP also indicated that an 11 30 09 dated MRI with contrast suggested an extruded disc at Left L4-5 with “likely” nerve compression. The claimant was noted to weigh 340 lbs. at 6’3” and had a normal neuro examination. The MRI’s from 11/09 were reviewed with findings as above. Prior AP records were reviewed, discussing an “extruded disc” into the epidural space and with inferior migration. The 12 14 09 denial letter was reviewed, with rationale that there was a normal neuro exam and no prior trial of ESI’s. The letter of appeal dated 1 5 10 from Dr. was reviewed. The 1 13 10 dated appeal reconsideration letter with denial was reviewed.

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

Without any objective examination findings of neurologic abnormalities of the extremities, and, without any bowel or bladder issues, the proposed procedure is not reasonably required as per applicable ODG Guidelines. The claimant’s intermittent back pain and leg symptoms alone (despite imaging studies) are insufficient to support the proposed procedure at this time.

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. 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

The reviewer notes that the ODG criteria were not met. Therefore, the requested service is not medically necessary based upon the documentation provided.

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)