



**Notice of Independent Review Decision**

**DATE OF REVIEW:** 08/17/11

**IRO CASE #:**

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

Outpatient Left Lumbar Lami/Disc L4-L5 63030 95920

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

Board Certified in Orthopedic Surgery

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Outpatient Left Lumbar Lami/Disc L4-L5 63030 95920 – OVERTURNED

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Lumbar Spine MRI, Imaging Centers 04/09/09
- New Patient Evaluation, M.D., 06/02/09
- Initial Evaluation/Examination, Outpatient Therapy Services, 06/05/09
- Progress/Treatment Note, 06/05/09, 06/11/09, 06/19/09, 06/23/09, 06/29/09, 07/01/09
- Physical Therapy Case Review, 06/18/09, 07/02/09
- Follow Up Examination, Dr. 06/23/09, 07/21/09, 08/18/09, 10/23/09, 12/18/09, 02/22/10, 10/22/10, 11/19/10, 01/12/11
- Procedure Note, Dr. 09/02/09, 09/25/09
- Correspondence, Dr. 11/03/09
- Notice of Disputed Issue(s) and Refusal to Pay Benefits, 03/04/10
- Evaluation, M.D., 03/03/11
- Approval Letter, 05/11/11
- Consultation, Back Institute, 06/08/11
- Radiology Report, Back Institute, 06/08/11
- Behavioral Medicine Evaluation, Back Institute, 07/01/11
- Denial Letter, Coventry, 01/07/11, 07/13/11

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient sustained a lifting type injury approximately two years prior. Since then, he has had major complaints of pain in the left side of the low back and the left leg. An MRI showed surgical changes at L5-S1, with no recurrent disc protrusion or abnormal enhancement. There was a small disc protrusion at L4-L5 without significant central canal stenosis. A course of physical therapy was started on 06/05/09. The patient then underwent two epidural steroid injections (ESIs), which helped with improvement. He was later started on Neurontin 300 mg, as well as Tramadol 50 mg. A repeat MRI scan was requested. Dr. recommended a microdiscectomy on the left at L4-L5. On 06/08/11, the Back Institute advocated for a surgical decompression discectomy and relieving the root compression.

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

The outpatient left lumbar laminectomy/discectomy is recommended. The ODG criteria for discectomy/laminectomy include:

1. Symptoms or findings which confirm presence of radiculopathy: This patient does have positive physical examination findings correlating with the subjective complaints.
2. Imaging Studies: The patient has an MRI scan from 01/25/11 revealing a large herniated lumbar disc at L4-L5.
3. Conservative treatment:

- a. Activity Modification: The patients activities were modified with restrictions.
- b. At least one of non-steroidal anti-inflammatory medication or other analgesic therapy, muscle relaxants, and epidural steroid injections: The patient has had multiple drug therapies.
- c. Support provider referral for at least one of physical therapy, manual therapy, psychological screening, or back school: The patient has had a psychological screening and physical therapy.

Therefore, the patient does meet ODG criteria and the surgical procedure is recommended for certification.

**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)**
- AMA 5<sup>TH</sup> EDITION**