

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/15/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left L3/4 and L5/S1 microdiscectomy and one day in-patient stay

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

MD, Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

Official Disability Guidelines
Adverse Determination Letters, 10/27/10, 11/18/10
Orthopaedic Associates 8/11/09-9/20/10
Outpatient Surgery 12/21/09
Radiology Associates 7/30/09
MRI Center 7/2/09
MD PA 1/28/10-6/30/10
Chiropractic Professionals 6/20/09-6/19/10
10/27/10, 11/18/10
11/18/10
D.C. 4/8/09

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury xx/xx/xx, when he was involved in an MVA. Physical therapy, chiropractic therapy, and ESIs were done. His examination 09/20/2010 reveals some lumbar spasm. An MRI of the lumbar spine 07/30/2009 reveals, at L3-L4 a 6mm central disc extrusion effacing the thecal sac and causing mild central stenosis. The neuroforamina are normal. At L4-L5 there is a 2-3mm circumferential disc bulge touching, but not effacing the thecal sac. The central canal and neuroforamina are normal. At L5-S1 there is a 6mm central disc extrusion, which is touching, but not effacing the thecal sac. There is no evidence of nerve root compression and the neuroforamina are intact. The provider is requesting a left L3-L4 and L5-S1 microdiscectomy with a one-day inpatient stay.

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

The left L3-L4 and L5-S1 microdiscectomy with a one-day inpatient stay is not medically necessary. The claimant has no evidence of radiculopathy or neurogenic claudication. He

appears to have axial back pain and his neurological examination is normal. His neuroimaging does not reveal any evidence of neural compression. His condition does not meet ODG criteria for discectomy/laminectomy. According to the ODG, in order for a discectomy/laminectomy to be medically necessary, there need to be "Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present." This is not the case for this claimant. Therefore, the requested left L3-L4 and L5-S1 microdiscectomy with a one-day inpatient stay is not medically necessary.

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)