



14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

DATE OF REVIEW: 7/19/2012

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Microlumbar discectomy, L4-5 bilaterally and microlumbar discectomy,
L5-S1 on the Left.

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

M.D. Board Certified Orthopedic Surgeon Fellowship Trained 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)



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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	6/29/2012
Review Med Utilization Review Determinations Medical Record Review Utilization Review Worksheet	6/11/2012-6/20/2012 11/10/2011 6/13/2012
M.D. Clinical Note Reviewed	7/03/2012
P.A. M.D. Authorization Request	5/22/2012
Family Care Center PA Laboratory Orders	6/06/2012
M.D. Clinical Note	6/20/2012
Nerve Conduction Evaluation PC Electrophysiological Report	9/15/2011
Facsimile Transmit	4/30/2012
Health Center, P.A. D.O. DD Exam	3/13/2012

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a female who sustained a low back injury after lifting a heavy container of syrup on xx/xx/xx. Her chief complaint is low back pain that radiates to both thighs. Her examination on 5/22/2012 showed pain with Lumbar range of motion, limitation of lumbar range of motion due to pain, and radiating pain to the thighs, with myotomal weakness consistent with L4 and or L5 distribution. A trial of conservative care to include pharmacotherapy, physical therapy, and injections were administered to address the complains of back pain radiating to the thighs with minimal relief.

MRI of the lumbar spine on 10/11/2011 showed small broad-based posterior disc protrusion noted at the L4-L5 and L5-S1 levels with associated high intensity zones and disc desiccation, moderate stenosis of the inferior aspect of the LEFT neural foramen was noted at L4-L5 Level.

Nerve Conduction findings and needle EMG examination in the lower extremities on 9/16/2011 suggested possible right L4 radiculopathy.

Eventually due to failure of conservative care, referral to a neurosurgeon was made.



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

Per ODG references the requested service for microlumbar discectomy L4-5 bilaterally, and microlumbar discectomy left L5-S1, is not medically necessary.

The decompression being requested does not co-relate the with MRI findings. There is minimal neurogenic compression evident from the MRI report to suggest any decompression at L4-L5 or L5-S1 would achieve any meaningful surgical outcome. At best the most significant findings is moderate LEFT sided foraminal stenosis at L4-L5. However, this and of itself does not justify surgical intervention, particularly when the patients symptoms of bilateral radiating pain into the thighs does not follow the pattern associated with the MRI findings and the EMG evident right sided findings rather than left sided findings. Essentially, there is scant evidence of frank neural compression based on the diagnostic MRI findings.

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