



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision

DATE OF REVIEW: 05/16/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Laminectomy/discectomy (CPT code 63030), microsurgical technique utilizing operating microscope (CPT code 69990), fluoroscopic guidance and localization (CPT code 77003), and lumbosacral orthosis (L0631)

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering degenerative disc disease

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
722.10	69990		Prosp.						Upheld
722.52	77003		Prosp.						Upheld
724.4	63030		Prosp.						Upheld
722.83	L0631		Prosp.						Upheld

INFORMATION PROVIDED FOR REVIEW:

**1908 Spring Hollow Path
Round Rock, TX 78681
Phone: 512.218.1114
Fax: 512.287-4024**

1. Certification of independence of the reviewer.
2. TDI case assignment.
3. Letters of denial 04/02/12, 04/11/12 & 04/18/12, including criteria used in the denial.
4. Treating doctor's H&P 03/23/12 and follow up 04/12/12.
5. Radiology reports 10/21/10 and 03/14/12.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The injured employee is a male who suffered an injury on xx/xx/xx. The mechanism of injury is not described in clinical information provided. The patient has complaints of low back pain and severe left leg pain with complaints suggestive of radicular symptoms. There is mention of extensive non-operative treatment including physical therapy, epidural steroid injection, and medications. There is no clinical documentation provided. There is mention of a prior surgical procedure, lumbar laminectomy, possible discectomy at the level of L4/L5 on the left side.

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

The diagnoses offered with this medical record include lumbar radicular syndrome, lumbar disc displacement, lumbosacral disc degeneration, and post laminectomy syndrome, lumbar. There is insufficient clinical information included to evaluate the extent to which radicular symptoms have been treated non-operatively. There is also little clinical information concerning the patient's injury of xx/xx/xx, and the prior surgery at level L4/L5 on the left side. In the absence of definitive clinical information including physical findings of an objective nature, it is difficult to confirm the diagnosis of radiculopathy. The prior denial of this request for lumbar laminectomy at the level of L5/S1 on the left side utilizing microsurgical technique was appropriate and should be upheld.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

- ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
- AHCPH-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 judgment, 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.

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- _____ TMF Screening Criteria Manual.
- _____ Peer reviewed national accepted medical literature (provide a description).
- _____ Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)