



# MedHealth Review, Inc.

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## Notice of Independent Review Decision

**DATE NOTICE SENT TO ALL PARTIES:** 9/18/12

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a right MIS L5/S1 microdiscectomy 63030 69990.

**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. The reviewer has been practicing for greater than 10 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 prospective medical necessity of a right MIS L5/S1 microdiscectomy 63030 69990.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr. history and physical notes x-ray report of lumbar spine.

Coventry: 7/30/12 denial letter, 7/5/12 denial letter, chart cover 11/28/11 to 7/20/12 office notes, right hip radiographic report without contrast 11/26/11 and 12/21/11, 12/21/11 pelvic radiographic report, 11/26/11 lumbar radiographic report, DD report 3/20/12, 3/15/12 FCE report, and 3/7/12 lumbar MRI report.

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant was noted to have persistent back and right leg pain ever since jamming his back when he stepped into a hole while carrying a heavy object. An MRI scan of the lumbar spine revealed disc protrusion at L5-S1 with nerve impingement. AP records note subjective numbness of the right leg on examination and an otherwise normal neurological examination. The 6-20-12 dated progress note did not evidence physical examination findings at all. Denial letters denote a normal neurological examination and the lack of detailed evidence of a trial and failure of physical therapy, and overall nonoperative treatment, consultation etc., including psychological evaluation.

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

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. 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

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

- 1. MR imaging
- 2. CT scanning
- 3. Myelography
- 4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following:

- A. Activity modification (not bed rest) after patient education ( $\geq$  2 months)
- B. Drug therapy, requiring at least ONE of the following:

- 1. NSAID drug therapy
- 2. Other analgesic therapy
- 3. Muscle relaxants
- 4. Epidural Steroid Injection (ESI)

C. Support provider referral, requiring at least ONE of the following (in order of priority):

- 1. Physical therapy (teach home exercise/stretching)
- 2. Manual therapy (chiropractor or massage therapist)
- 3. Psychological screening that could affect surgical outcome
- 4. Back school

There is a lack of significant abnormal neurologic findings on examination of the lower extremities. There is also a lack of detailed documentation of physical therapy records/overall trial and failure of non-operative treatment methods. A psychological evaluation-screen has not been documented. Therefore, applicable clinical guidelines do not support the requested procedure at this time, as referenced above. Therefore all of the criteria for the requested procedure have not been met and the requested procedure is not medically necessary at this time.

**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)**