

## IRO REVIEWER REPORT TEMPLATE -WC

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Notice of Independent Review Decision

**Date notice sent to all parties: 5/15/13**

**IRO CASE #:**

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

Back surgery on Disk L5-S1/Recon Re exploration L5/S1 63042 to complete by 5/26/13

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

Texas Licensed, Board Certified Orthopedic 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)

Provide a description of the review outcome that clearly states whether medical

necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

1. 1/28/13 and 3/22/13 Denial Letters
2. Appeal Request
3. 1/23/13 Pre-auth request
4. 12/30/08-2/5/13 MD notes
5. 12/17/08 MD Operative Report
6. 12/26/12 MRI Spine Lumbar w/ and wo/ Contrast
7. 2/20/13 Authorization Request
8. 4/8/2008 MRI Lumbar W.WO
9. 7/25/07 MRI Lumbar WO
10. 4/1/13, MD Complete Rationale for Preauthorization
11. 11/1/07 Advanced Diagnostics report

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant was noted in xxxx to have had a xx fall on top of him while working. He was treated medically and then ultimately required a surgical intervention for his persistent back pain with sciatica. In fact, he underwent on 12/07/2008 a discectomy for an extruded disc at the L5-S1 level. Previously, to that extruded disc as part of the work, he had been noted on 07/25/2007 to have an extruded disc on MRI. Subsequently to the surgery in December 2008, he underwent an MRI of 2009 because he was having some type of persistent back pain with radiation. On that MRI of 04/19/2009 as described in the report reviewed, he was noted to have mild disc bulges at L4-L5 and L5-S1. However, the claimant was noted to subsequently become even more symptomatic despite the use of medications and physical therapy and restricted activities, at the least he was noted on 12/26/2012 to have what was rather a large right-sided disc protrusion with mass effect on S1. Markedly greater than the postoperative MRI from treating half years earlier.

From the recent records from January 2012 and from 02/05/2013, the treating provider documented the low back pain with right leg sciatica along with weakness of the anterior and posterior tibialis and absent right ankle jerk and decreased sensation in the L5-S1 dermatome right lower extremity. He documented the trial and failure of nonoperative intervention and proposed surgical intervention either discectomy and/or discectomy plus fusion.

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

The claimant does have a medical necessity of the requested back surgery at the level of L5-S1 with reexploration of that disc space. The claimants as per the applicable ODG guidelines regarding laminectomy and discectomy, has had a reasonable trial and failure of extensive nonoperative treatment. The claimants has been noted to have both subjective findings and objective findings that are compatible with the imaging finding and the imaging findings are compatible with the L5-S1 disc extrusion/protrusion/ recurrent herniation. The

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ODG guidelines explicitly does discuss that for a L5-S1 disc abnormality including a likely S1 radiculopathy. There is a consideration for surgical intervention should reasonable nonoperative treatment be tried and failed. In this case, the proposed CPT code 63042 does reasonably address the fact that there is a consideration for this redo decompressive discectomy, laminectomy with exploration of disc space and it is an appropriate code. The surgical procedure in itself with the associated code is reasonable and medically necessary based on the overall subjective and objective findings and the associated imaging and the prior denials should be in this review of his opinion overturned based upon a thorough review of the submitted records and the evidence based ODG criteria.

### **REFERENCE:**

ODG guidelines, low back chapter, discectomy and laminectomy.

**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**
- X 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**
- X 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):**