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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/06/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: L4-L5 MITR and discectomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery and Fellowship Trained Spine Surgery

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 health care service in dispute. It is the opinion of this reviewer that medical necessity for L4-L5 MITR and discectomy is not established

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx while lifting over the right shoulder with acute onset of low back pain radiating to the right lower extremity. The patient was reported to have had a large central disc herniation at L4-5 on MRI from 05/12 which was not available for review. Conservative treatment included Norco and Naproxen. The patient received physical therapy sessions in 2012 with no long term improvement. Updated MRI of the lumbar spine on 10/31/13 noted disc desiccation at L4-5 with a 3mm disc herniation slightly indenting the thecal sac. The neural foramina appeared patent. Posterior elements were within normal limits. The patient did not wish to undergo epidural steroid injections. There appeared to have been a prior electrodiagnostic study performed; however, this was not available for review. The patient was seen on 02/18/14 with persistent swelling and pain in the right side of the low back and lower extremities. On physical examination there was significant paraspinal tenderness to palpation in the lumbar spine with some radiating symptoms reported in the lower extremities. Range of motion was decreased. Mild weakness at the right extensor halluc longus was noted. There was dyesthesia at the right foot in L5 distribution. Straight leg raise testing was positive. The patient was recommended for discectomy utilizing minimally invasive tubular retraction system at this evaluation. The requested MITR discectomy was denied by utilization review on 03/04/14 as no MRI was available for review. The request was again denied by utilization review as there were no Official Disability Guidelines indications for tubular microdiscectomy procedures over standard microdiscectomy procedures.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for persistent complaints of low back pain radiating to the lower extremities right lower extremity

that has not improved with conservative treatment including physical therapy and anti-inflammatories. The patient did not wish to undergo epidural steroid injections. MRI of the lumbar spine available for review noted a small disc herniation at 3mm measuring 3mm at L4-5 with moderate spondylitic change. There was no evidence on MRI of any neural foraminal compromise that would reasonably correlate with objective findings including mild weakness at the right extensor hallucis longus or sensory loss in L5 distribution to the right. It appears that prior electrodiagnostic studies were performed for this patient but were not available for review. No other imaging studies were available for review identifying clear nerve root impingement at L4-5 that would reasonably warrant discectomy procedures as outlined by current evidence based guidelines. As such it is the opinion of this reviewer that medical necessity for L4-L5 MTR and discectomy is not established and the prior denials are upheld.

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)