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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/17/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left L5-S1 microdiscectomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery, 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 this reviewer's opinion that the proposed L5-S1 microdiscectomy would be medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who has been followed for complaints of pain in the low back radiating through the right lower extremity without numbness, paresthesia, or weakness. The patient indicated she began to develop low back pain radiating to the lower extremities. Initial MRI studies of the lumbar spine from xxxxx noted a 12 x 7mm left sided central disc extrusion with a slight inferior migration narrowing the left lateral recess with impingement of the traversing left S1 nerve root. The patient's conservative treatment did include 1 month of physical therapy which did improve symptoms. No further physical therapy was allowed and the patient's pain returned. The patient did receive trigger point injections as well as 1 epidural steroid injection which provided some benefit; however, this was short lived for 2 weeks only. The patient reported limited benefits from anti-inflammatories. A repeat MRI of the lumbar spine performed on 03/07/14 again noted a 4mm disc protrusion at L5-S1 with a central annular tear producing mild central canal stenosis as well as lateral recess narrowing. The patient was seen on 03/20/14 with continuing complaints of low back pain with weakness in the left lower extremity. Physical examination noted continuing weakness at the left extensor hallucis longus and on plantar flexion. There was decreased sensation in a left S1 distribution. Reflexes were trace to absent in the left ankle. Follow up on 05/01/14 noted no change to physical examination. The patient was continually recommended for an L5-S1 left microdiscectomy.

The requested L5-S1 microdiscectomy was denied by utilization review on 02/18/14 as there had been no performance of an updated non-contrasted MRI of the lumbar spine.

The request was again denied by utilization review on 03/28/14 as there had been no documentation regarding physical therapy or a psychological screen.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has presented with persistent complaints of low back pain radiating to the left lower extremity. Imaging studies did note a disc protrusion at L5-S1 primarily to the left side with impingement of the left S1 nerve root. The patient did have concordant physical examination findings to include motor weakness at the extensor hallucis longus and on plantar flexion as well as decreased sensation in a left S1 distribution and trace to absent reflexes in the left ankle. These physical examination findings are consistent with imaging findings. The patient has not improved overall with conservative treatment that has included epidural steroid injections, physical therapy, the use of anti-inflammatories, as well as trigger point injections. Given the failure of conservative treatment to date, it is this reviewer's opinion that further non-operative measures would not likely improve the patient's overall functional ability. The patient continues to have active radiculopathy that has not improved with conservative treatment. Therefore, it is this reviewer's opinion that the proposed L5-S1 microdiscectomy would be medically necessary as outlined by current evidence based guidelines. As such, the prior denials are overturned.

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)