P-IRO Inc.

An Independent Review Organization

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Notice of Independent Review Decision

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Neurosurgery

Description of the service or services in dispute:

Intra-operative monitory during left L4-L5 microdiscectomy

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)

Patient Clinical History (Summary)

The patient is a male. On 08/28/14, MRI revealed acute central L4-5 disc extrusion. There was 25% spinal canal stenosis and contact of L5 nerve roots. Other levels demonstrated no disc herniation or stenosis. On 02/06/15, the patient was taken to surgery and procedure was performed with neurophysiological monitoring.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 01/28/14 01/28/15, utilization review determination letter approved left L4-5 microdiscectomy. On 02/04/15, utilization review determination letter stated the quested procedure intraoperative monitoring for the left L4-5 microdiscectomy was not medically necessary. Case discussion occurred with treating provider who stated monitoring was standard in his area. At the time of submission no additional information had been received support the quest and therefore determination would not remain unchanged. Guidelines indicate this procedure may be considered reasonable for spinal or intracranial surgeries when such procedures have risk of significant complications that can be detected at their venting prevented through the use of neurophysiological monitoring. Left L4-5 microdiscectomy would not in all medical probability would have caused significant risk at would not have caused risk of significant complications that could be evaluated through the intraoperative monitoring. Therefore, it is the opinion of this reviewer that the request is not medically necessary 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 and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ 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 and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)