

P-IRO Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: May 17, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient lumbar anterior and posterior discectomy, corporectomy, and fusion at L5-S1 with allograft, posterior segmental fixation with 2 day LOS.

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

MD board certified; American Board of Neurological 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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. A lumbar MRI report of 8-15-2006 by MD.
2. A CT discogram report of 3-8-2007 by MD, and MD.
3. An operative report for L5-S1 bilateral facet injections by MD, on 11-7-2006.

4. An operative report regarding lumbar epidural steroid injections on 10-4-2006.
5. A 2-5-2007 Forte report.
6. utilization review findings of 4-3-2007 and 4-11-2007.
7. Institute reports of 2006 by Drs.
8. A report by MD, on 2-5-2007.
9. Case Assignment fro TDI
10. Denial Letters from the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a female who developed back and right lower extremity pain after she attempted to pick up a student at work. Medications and physical therapy were not successful in dealing with the trouble, and a lumbar MRI on 5-17-2006 showed chronic changes in the upper lumbar spine and a possibility significant lumbar L5-S1 disc rupture. Epidural steroid injections were done on 6-27-2006, without help. A repeat MRI on 8-15-2006 showed a small central disc herniation at the L5-S1 level with only questionable S1 nerve root impingement. Epidural steroid injections were repeated on 10-4-2006, and facet blocks bilaterally at the L5-S1 level on 11-7-2006, were also done. The patient's pain continues, requiring medications. Discography at the lumbar L4-5 and L5-S1 levels on 3-8-2007 showed probable concordant pain at the L5-S1 level only, with changes on the subsequent CT scan suggesting disc pathology at that level which could be responsible for her discomfort. The L4-5 level was negative not only at the time of injection but on the follow-up CT scan. Of significance to note also is that on 7-14-2006 lumbar spine films with flexion and extension views were done and failed to show any instability.

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

The Reviewer agrees with the denial for the proposed operative procedure. This patient's symptoms and imaging studies suggest difficulty at the L5-S1 level, but instability at that level is not a factor. Despite the MRIs not distinctly showing nerve root compression at that level, the Reviewer thinks one has to assume that as a possibility considering her persistent symptomatology despite rather extensive conservative management including multiple injections. The proposed operative procedure may eventually have to be pursued but to pursue that on a first time basis in a lady, without evidence of instability or other changes such as spondylolisthesis, is not thought indicated.

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)**