

I-Decisions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient lumbar x-rays, flexion and extension

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter low back, radiograph

DDE, Dr., 06/11/08

Office notes, Dr. 07/13/09, 07/14/09

Peer review, 12/24/09

Peer review, 01/05/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male with complaints of back and leg pain. Reportedly, the MRI of the lumbar spine from 03/03/08 showed multilevel lower lumbar degenerative disc disease, findings fairly mild, and a small central and left paracentral annular tear at the L5-S1 level and 04/03/08 electromyography findings consistent with L5-S1 radiculopathy. Dr. evaluated the claimant on 07/14/09. X-rays of the lumbar spine including flexion and extension views that day showed L5-S1 extension angle measured 18 degrees with spondylosis, facet subluxation, and foraminal stenosis. L4-5 extension angle measured 21 degrees with facet subluxation, lateral recess stenosis, and pinhole foraminal stenosis. Examination revealed weakness of the gastrocnemius soleus on the left and paresthesias in the L5 and S1 nerve root distribution on the left. Positive Lasègue's on the left was noted. Diagnosis was lumbar clinical instability with herniated nucleus pulposus with left radiculopathy with failure of conservative treatment greater than 17 months. Dr. recommended decompression, discectomy and stabilization at L4-5 and L5-S1.

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

The records available in this case confirm flexion and extension views obtained in July of 2009. There is nothing to suggest that these views were suboptimal or in any way flawed. There are no records to suggest a change in the claimant's condition since those views were obtained. As such, the reviewer is unable to recommend repeated films to include flexion

and extension views as medically necessary, as this diagnostic test already appears to have been performed. The reviewer finds that medical necessity does not exist for Outpatient lumbar x-rays, flexion and extension.

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)