

SENT VIA EMAIL OR FAX ON
Oct/28/2010

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

Corrected 10/28/10

Date of Notice of Decision: Oct/28/2010

DATE OF REVIEW:

Oct/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient 1-2 days; L5/S1 Decompressive Laminectomy, Discectomy, PLIF, Internal Fixation with Cages, Posterior Instrumentation with Rods and Screws to include CPT coes 63030, 22842, 22851, 22630

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

OD Guidelines

Denial Letters 10/1/10 and 9/3/10

OHS 10/1/10

Dr. 1/20/10-9/7/10

Dr. 8/5/10

EMG.NCV 5/3/10

MRI 1/14/10

Dr. 12/30/09

X-Ray 5/3/10

PT Eval 1/25/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury xx/xx/xx, when he was lifting bundles of insulation off a truck, slipped, and twisted his back. He complains of low back pain radiating to the lower extremities. He has taken pain medications, NSAIDs, ESIs, and undergone physical therapy. His neurological examination 09/07/2010 reveals that deep tendon reflexes were decreased at the ankles. There is decreased sensation at L5-S1, right greater than left. An MRI of the lumbar spine 01/14/2010 reveals a spondylolisthesis at L5-S1 with a disc protrusion at L5-S1 without spinal stenosis or neuroforaminal narrowing. Electrodiagnostic testing 05/03/2010 reveals a right mild L5 subacute radiculopathy. Plain films of the lumbar spine with flexion and extension 05/03/2010 reveal a grade I spondylolisthesis of L5 on S1 with bilateral spondylolysis. The provider is requesting an L5/S1 Decompressive Laminectomy, Discectomy, PLIF, Internal Fixation with Cages, Posterior Instrumentation with Rods and Screws to include CPT codes 63030, 22842, 22851, 22630 with a 1-2 day inpatient stay.

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

The proposed surgery is not medically necessary, based on the submitted documentation. While the claimant may ultimately be a surgical candidate, there is insufficient information to support the medical necessity of this procedure. The claimant has failed conservative measures and appears to have lumbar pathology limited to a single level: L5-S1. However, there is no neuroforaminal or central stenosis, and no significant neurologic deficits on examination. According to the ODG, "Low Back" chapter, a "psychosocial screen with confounding issues addressed" should be performed prior to a lumbar fusion. This does not appear to have been done, based on the submitted documentation. Given no significant neurologic deficits or gross instability, this should be done prior to a lumbar fusion. Therefore, the procedure remains not medically necessary at this time.

References/Guidelines

ODG "Low Back" chapter

Patient Selection Criteria for Lumbar Spinal Fusion:

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)