

SENT VIA EMAIL OR FAX ON
Feb/22/2011

IRO Express Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Feb/21/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4-5-S1 Lumbar lamiectomy, discectomy arthrodesis with cages, posterior instrumentation, implantation bone growth stimulator (EBI) L3/4 discectomy only 2 days inpatient stay

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

Board Certified Orthopedic Surgeon, Practicing Neurosurgeon

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

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a xx-year-old female who injured her low back moving a heavy weight, resulting in quite significant pain in lumbar spine, bilateral lower extremities, and resulting in cervical spine discomfort and headaches. MRI of lumbar spine dated 10/24/08 revealed posterior left paracentral and left posterolateral protruded herniated disc measuring 4.6 mm with thecal sac impingement and proximal left neural canal narrowing at L3-4. Posterior central disc bulges were noted at L4-5 (minimal disc bulge), and L5-S1. Electrodiagnostic testing performed on 09/30/08 reported EMG/NCV of bilateral lower extremities were normal with no signs of acute or chronic motor radiculopathy and no signs of neuropathy of bilateral lower extremities. Records indicate the injured employee reported undergoing formal course of physical therapy, but denies having undergone injections of any type. The injured employee was seen for surgical consultation on 02/23/10. Examination at that time reported positive spring test at L4-5 and L5-S1, positive extensor lag, positive sciatic notch tenderness bilaterally, worse on left, positive flip test bilaterally, positive Lasegue's on left at 45 degrees, positive Braggard's, decreased knee and ankle jerk on left, absent posterior tibial tendon jerk bilaterally, paresthesias in L5-S1 root distribution on left, and

weakness of gastrocnemius and EHL on left. A pre-surgical psychological evaluation was performed on 05/27/10 and the injured worker was recommended to participate in individual psychotherapy x 6 sessions.

A request for L4-5-S1 lumbar laminectomy, discectomy arthrodesis with cages, posterior instrumentation, implantation of bone growth stimulator (EBI), L3-4 discectomy only and two-day inpatient stay was reviewed on 12/22/10. Dr. determined the request to be non-certified, noting there was insufficient clinical evidence regarding lumbar radiculopathy that would support discectomy procedures at L3-4. Dr. noted the MRI study does reveal a left sided disc extrusion at L3-4 causing neural foraminal stenosis, but electrodiagnostic studies were normal. Patient was noted also to have evidence of decreased sensation in the L5-S1 dermatome that is not consistent with MRI findings. Dr. noted the patient was stated to have clinical instability on flexion extension views, but no independent radiographic studies were provided that support motion segment instability at any level of the lumbar spine. There was minimal clinical documentation regarding the patient's prior conservative therapy and no updated neurologic or orthopedic exam was submitted for review as the clinic note was from 05/10.

A reconsideration/appeal request was reviewed on 01/18/11. Dr. determined that the reconsideration request was non-certified noting that the proposed treatment plan was not consistent with the clinical review criteria.

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

Based on the clinical information provided, medical necessity is not established for the proposed surgical procedure with L4-5-S1 lumbar laminectomy, discectomy arthrodesis with cages, posterior instrumentation, implantation bone growth stimulator (EVI), L3-4 discectomy only and two-day inpatient stay. The injured work sustained an injury to the low back. She complains of low back pain and bilateral lower extremity pain. MRI revealed a 4.6mm posterior left paracentral and posterolateral disc protrusion/herniation at L3-4 narrowing the left neural canal. Posterior central discs were noted at L4-5 and L5-S1, with no evidence of stenosis or nerve root impingement at either level. Electrodiagnostic study on 09/30/08 was reported as a normal study with no evidence of radiculopathy or neuropathy. There was limited information concerning conservative treatment completed to date for the injured employee, with no indication that the patient had a trial of diagnostic and possibly therapeutic epidural steroid injections. Although the patient reportedly had evidence of instability at L4-5 and L5-S1, no independent radiology reports were provided with objective documentation of motion segment instability at any level. As such medical necessity is not established for proposed surgical procedure, and previous determinations appropriately determined non-certification.

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)