

SENT VIA EMAIL OR FAX ON
Jul/18/2011

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/18/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Revision Lumbar Laminectomy & Discectomy, Fusion with Instrumentation, Implanture Bone Growth Stimulator with 2 days length of stay

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

M.D., Board Certified 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

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xx. Records indicate he was lifting and pulling a scaffold when he felt immediate pain in his low back. The injured employee underwent conservative treatment including medications, physical therapy and lumbar epidural steroid injections. He subsequently underwent bilateral L4-5, L5-S1 laminotomy, discectomy, and foraminotomy performed on 07/15/09. MRI of lumbar spine performed 05/19/10 reported early desiccation of L4-5 and L5-S1 with no evidence of disc herniation at any level throughout the lumbar region and no other compromise of spinal canal or neural foramina. Electrodiagnostic testing performed on 06/20/10 reported evidence of moderate acute S1 radiculopathy on right and left side, and also evidence of mild irritation on L5 level. CT of lumbar spine on 11/19/10 revealed mild diffuse bulge of L3-4 disc with small right posterolateral disc protrusion at L5-S1 causing moderate right and neural foraminal stenosis. Lumbar spine x-rays on 05/15/09 including AP/lateral/flexion/extension views reported fixed retrolisthesis at L4 on L5, disc height loss at L5-S1; no evidence of lumbar spine fracture. X-rays on 06/14/11 reported mild loss of vertical disc height at L4-5 with moderate loss of vertical disc height at L5-S1, with 3 mm of retrolisthesis at L4-5 extension 2 mm of retrolisthesis at L2-3 and L3-4. There was neutral alignment at all three levels in flexion. There is no other significant segmental motion. The injured employee was seen by Dr. on 05/24/11 with complaints of back pain and bilateral leg pain, left worse than right. Dr.

assessment was failed lumbar spine syndrome with clinical instability at L4-5 and L5-S1 with recurrent HNP at L5-S1 with left greater than right radiculopathy with conservative treatment. Dr. recommended the injured employee undergo revision lumbar laminectomy and discectomy, fusion with instrumentation and implantation of bone growth stimulator.

A preauthorization request for revision lumbar laminectomy and discectomy, fusion with instrumentation, implantation of bone growth stimulator, and 2 day inpatient stay was reviewed and adverse determination recommended per report dated 06/01/11. The rationale noted the injured employee was a known case of failed lumbar spine syndrome with clinical instability at L4-5 and L5-S1 with recurrent herniation at L5-S1. Signs and symptoms are bilateral predominately on left. Conservative treatment has been provided for nearly two years with no apparent improvement; however, no independent radiology report of flexion / extension lumbar x-rays was provided for review. Also, there is no updated psychiatric screening showing clearance for procedure. There was also no documentation of the injured employee's objective response to recent physical therapy, home exercise program, and current pharmacotherapy showing failure of conservative treatment.

An appeal preauthorization request for revision lumbar laminectomy and discectomy, fusion with instrumentation, implant bone growth stimulator, with two day inpatient stay was recommended for adverse determination per report dated 06/28/11. The reviewer noted that the information submitted was scanned as recent medical information, but showed no instability with some obvious clinical suspicions and radiographic suggestions to suggest recurrent nerve compression. Why fusion surgery is being contemplated is not clear. Phone conversation would be necessary to discuss why fusion is necessary. As requested current evidence based literature does not support the request as submitted.

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

The request for revision lumbar laminectomy and discectomy, fusion with instrumentation and implant bone growth stimulator with a two day inpatient length of stay is not indicated as medically necessary. The injured employee is noted to have sustained an injury to the low back while lifting and pulling. After undergoing a course of conservative care, the injured employee underwent bilateral L4-5, L5-S1 laminectomy, discectomy and foraminotomy on 07/15/09. He continued to complain of low back pain with bilateral left greater than right leg pain. The injured employee had multiple diagnostic/imaging studies done post-operatively which revealed a small right posterolateral disc protrusion at L5-S1, with electrodiagnostic evidence of moderate acute S1 radiculopathy and mild irritation at L5 level. Lumbar spine x-rays with lateral flexion extension views revealed mild retrolisthesis at L4-5 and at L2-3 and L3-4 with neutral alignment at all three levels in flexion. Per AMA Guidelines, the injured employee does not meet criteria for motion segment instability which requires 5mm of motion. Also there is no pre-surgical psychological evaluation addressing confounding issues. Given the current clinical data, medical necessity is not established for the proposed surgical procedure and the previous determinations 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 & 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)