

SENT VIA EMAIL OR FAX ON
Jul/20/2011

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Jul/20/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right L5-S1 Laminotomy/Disectomy with use of microscope 63030,69990; 2 Day 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
OD Guidelines

1. Operative report 06/25/10
2. Designated doctor evaluation 10/13/10
3. Clinical records Dr. 01/11/11
4. Clinical records Dr. 03/21/11
5. MRI lumbar spine 03/25/10
6. MRI thoracic spine 03/25/10
7. Psychiatric evaluation 04/05/11
8. Utilization review determination 04/13/11
9. Utilization review determination 06/10/11
10. Utilization review determination 07/01/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have a date of injury of xx/xx/xx. On the date of

injury she was pushing a charger where she developed when she developed low back pain. Records indicate that the claimant was referred for MRI of the lumbar spine on 03/25/10 which notes moderate degenerative changes of the lower lumbar spine with a right paracentral disc protrusion at L5-S1 producing severe narrowing of the right lateral recess with impingement upon the left S1 nerve root with mild to moderate left neural foraminal narrowing at L5-S1. The records further include an MRI of the thoracic spine which showed mild degenerative changes without evidence of significant spinal canal stenosis or neural foraminal stenosis. Records indicate that on 06/25/10 the claimant underwent epidural steroid injections with no apparent improvement post procedurally. A repeat MRI was performed on 09/15/10. This is reported to show multilevel spondylosis with degenerative changes at L3-4 with a broad based disc bulge containing evidence of an annular fissure. At L4-5 there are degenerative changes and narrowing with a 3cm central disc protrusion with high signal suggestive of an annular fissure. There are hypertrophic changes of the posterior elements with mild central canal stenosis. At L5-S1 there are degenerative changes and narrowing of post surgical changes and a broad based anterior extradural defect likely a combination of a broad based disc bulge protrusion. The claimant is reported to have been treated with oral medications and physical therapy. The claimant was seen by designated doctor on 10/13/10. On physical examination she's noted to be 5'8" tall and weighs 257 pounds. She walks with a cautious but normal gait. She can walk on her heels and toes. There is no sign of sensory deficit. Range of motion was limited in all planes. Review of MRI dated 03/25/10 is reported to show a significantly large disc herniation at L5-S1 on the right. It was reported that the claimant does not want to have surgery so at this time the designated doctor placed her at clinical maximum medical improvement with a 10% whole person impairment rating.

On 01/12/11 the claimant was seen in follow up by Dr.. It was reported she's had no significant relief with any of her injections. She reports that physical therapy is not benefitting her. She's having minimal relief with anti-inflammatories. She's currently working without restrictions but is having a great deal of difficulty sitting for any extended period of time. On physical examination she's reported to have a mildly positive straight leg raise with reproduction of symptoms into her S1 and L5 distributions. Strength globally is reported to be 5/5. She's uncomfortable when sitting for significant periods. She has a moderately diminished patellar reflex but this appears to be equal bilaterally. Her Achilles reflexes are within normal limits. It's opined that the claimant has failed conservative care and she subsequently is recommended to undergo a right sided L5-S1 laminotomy microdiscectomy.

On 03/21/11 the claimant was seen by Dr. who notes that the request for a right L5-S1 laminotomy with discectomy and microscope was denied. The reasons for denial include an absence of psychological screening. The claimant was subsequently referred for psychiatric evaluation which was performed on 04/05/11. The evaluator notes that the claimant's pain is severely impacting her normal function both physically and interpersonally and that there is no evidence of factors which would indicate a negative outcome from an invasive procedure. She was found to be an appropriate candidate for surgery from a psychological perspective. She's noted to present with few indicators of depression and anxiety. On 06/10/11 the initial request for right L5-S1 laminectomy discectomy and intraoperative microscope was non-certified by Dr.. Dr. notes that clinical records indicate that the claimant has buttock and leg pain. On examination there's mildly positive right straight leg raise with reproduction of symptoms in the L5 and S1 distribution her strength is globally intact. She has diminished patellar reflex. Physical therapy progress notes were not provided showing the reviewer that the claimant had maximized functional response to conservative measures. He further reports there's a lack of supporting documentation to establish the failure of other modalities. He therefore finds the request to be non-certified. An appeal request was submitted subsequently reviewed on 07/01/11 by Dr. who notes that there was an adverse determination of a previous review. He notes that an acknowledgement of the previous non-certification due to the lack of documentation of failure of conservative treatments there is now documentation per the medical records that the claimant complains of buttock and leg pain. Dr. notes that the records indicate that the claimant has had medication injections and physical therapy. He reports that there were no clear documentations of associated clinical findings such as the loss of relevant reflexes, muscle weakness and/or atrophy of the

appropriate muscle groups' loss of sensation and therefore medical necessity has not been substantiated

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

The request for right L5-S1 laminotomy discectomy with use of a microscope code 63030, 69990 and two day inpatient stay is recommended as medically necessary and the previous determinations are overturned. The preponderance of the evidence in the clinical file indicates that the claimant has a history of low back pain with radiation into the lower extremity. She's been identified as having a large focal right paracentral disc protrusion which contacts and impinges the right S1 nerve root. The claimant has previously been approved for lumbar epidural steroid injections which failed to provide any significant relief. She's further documented adequately in the chart that the claimant has undergone physical therapy. The claimant has been seen by a designated doctor who clearly felt the claimant was a surgical candidate. However the claimant was not interested in surgical intervention at that time. Per the designated doctor the claimant has a diagnosis of right S1 radiculopathy in conjunction with chronic back pain. The claimant has undergone a pre-operative psychiatric evaluation which shows no barriers to the performance of surgery. Based upon the totality of the clinical information there is sufficient data there to establish that the claimant has failed all conservative care as previously been accepted as having a lumbar radiculopathy for which she received interventional treatments and therefore she has failed conservative care and requested procedure is consistent with current evidence based recommendations.

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)