

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/05/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Posterior Lumbar Interbody Fusion @ L4/5; 3 day inpatient stay

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

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

Request for IRO 09/21/11

Request for IRO 09/20/11

Utilization review determination 08/17/11

Utilization review determination 08/25/11

MRI lumbar spine 03/11/10

MRI lumbar spine 02/25/11

Clinical records Dr. 04/12/10 through 08/09/11

Procedure report right transforaminal epidural steroid injection 05/13/10

EMG/NCV study 05/05/11

Designated doctor report 02/11/11

Electrodiagnostic studies review 05/27/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have sustained work related injuries on xx/xx/xx. She's reported to have been on a lunch break when she slipped on a wet floor landing on a knee backwards developing low back pain with bilateral leg pain. It is reported that she was scheduled to have surgery and then found out she was pregnant. She's been scheduled for surgery on her left knee. On 04/12/10 the claimant was seen by Dr. Claimant is noted to have a history of diabetes gastric bypass and tubal ligation. On physical examination she's 68 inches tall weighs 178 pounds. She's well developed well nourished. Her reflexes are 2+ and symmetric. Motor strength is noted to be 4/5 in the left EHL. Straight leg raise is reported to be positive. She's noted to have tenderness over the lumbosacral junction. MRI is reported to show an L4-5 central disc protrusion causing central canal stenosis with a

7.4mm AP diameter bilateral recess stenosis with foraminal encroachment and a central L5-S1 disc protrusion with mild canal stenosis with a 9mm AP diameter. She's recommended to undergo a lumbar discectomy and fusion with epidural steroid injection. Records indicate the claimant was seen in follow up on 05/04/10 and is noted to be two week status post knee surgery. Her physical examination is unchanged. She is pending epidural steroid injection. She is recommended to have Cymbalta. On 07/20/10 the claimant is noted to be status post epidural steroid injection. She requests a second epidural steroid injection and she reports episodes of urinary incontinence. Records indicate the claimant was largely treated with oral medications. She subsequently is reported to have bilateral symptoms. The most recent clinical note submitted is dated 08/09/11. She continues to have low back pain bilateral leg pain right greater than left. She underwent EMG/NCV. She is opined to have leg pain with evidence of L5 radiculopathy. She subsequently is recommended to undergo surgical intervention.

The record includes electrodiagnostic study review performed by Dr. on 05/27/11. Dr. disagrees with diagnosis of radiculopathy and notes there is no medical or electrodiagnostic evidence of lumbar radiculopathy at any level.

The most recent imaging study presented is MRI of lumbar spine dated 02/25/11. This study re-demonstrates at L4-5 decreased degenerative disc signal with central disc protrusion causing central canal stenosis with 7.4 mm AP sac diameter. There is bilateral recess stenosis and neural foraminal encroachment bilaterally which is stable when compared to prior study. At L5-S1 there is central disc protrusion with mild canal stenosis with 9 mm AP sac diameter which is stable.

The initial request for surgery was reviewed by Dr. Dr. non-certified the request. A peer to peer was conducted with Dr. on 08/15/11. The case was discussed. He reported the patient will need fusion given wide decompression. He reported additional documentation would be faxed; however, no additional clinical information was received. It is further noted that no psychosocial evaluation was submitted for review. She is noted to have history of depression and anxiety and suicide thoughts. As such, he finds the request not to be medically necessary or appropriate.

The appeal review was performed by Dr. on 08/25/11. Dr. non-certified the request noting the previous reviewer noted missing criteria. He notes there is no documentation of diagnosis or condition with supported objective findings and imaging studies for which fusion is indicated such as instability. He further notes there remains no documentation of psychological evaluation for the procedure. As such he upholds the previous determination and non-certified the request.

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

The request for posterior lumbar interbody fusion at L4-5 and 3 day inpatient stay is not supported by the submitted clinical information, and the previous utilization review determinations are upheld. The records indicate the claimant sustained injuries as a result of slip and fall occurring on xx/xx/xx. Records indicate the claimant has been treated with oral medications, physical therapy, and a single epidural steroid injection without relief. The claimant has undergone imaging studies which indicate presence of large disc herniation at L4-5 which would be amenable to decompression and discectomy. There is no documented instability. The records do not include lumbar flexion and extension radiographs. The claimant has not been referred for preoperative psychiatric evaluation, and as such would not meet ODG guidelines for performance of this procedure. Based upon totality of the medical information submitted, the request is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

- 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)