

SENT VIA EMAIL OR FAX ON  
Mar/27/2012

## IRO Express Inc.

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Mar/27/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Three (3) day length of stay for L4-L5-S1 lumbar laminectomy, discectomy; L5-S1 arthrodesis w-cages, posterior

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

Orthopedic spine 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

Notice of utilization review findings 03/01/12

Notice of intent to issue adverse determination 02/29/12

Notice of utilization review findings 03/08/12

Notice of intent to issue adverse determination 03/07/12

Preauthorization request and appeal request

New patient surgical consultation and office visit 09/28/10 and 02/21/12

Authorization for requested services 12/14/10

Procedure note lumbar discography 10/17/11

Initial examination and progress notes D.C. 11/06/09-02/07/12

Contested case hearing decision and order 01/13/12

Mental diagnostic screening update with mental health testing and treatment progress notes 09/12/11-12/29/11

Treatment progress report presurgical screening 11/28/10

Treatment progress report 05/06/10

Treatment progress notes individual psychotherapy 03/17/10-04/21/10  
Initial diagnostic screening 02/10/10  
Electrodiagnostic interpretation 08/18/10  
Electrodiagnostic results 07/30/10  
MRI lumbar spine 07/21/10  
Office visit notes, M.D. 07/08/09-10/22/09  
Operative report left knee medial meniscectomy 09/10/09  
Employees report of injury xx/xx/xx  
Notice of disputed issues and refusal to pay benefit 07/31/09  
MRI scan left knee 06/29/09  
Chest x-ray 09/01/09  
MRI left knee 01/07/10  
Functional capacity evaluation 08/16/11  
X-rays bilateral knees 10/28/11  
Encounter notes and physical therapy notes MD 06/04/09-07/20/09  
Office notes, MD 09/10/09-01/25/12  
New patient evaluation MD 12/16/09  
Operative report left knee arthroscopy 02/12/10  
Evaluation report including impairment rating evaluations DC 01/14/10-01/26/12  
Consultation and follow-up notes MD 06/16/10-11/01/11  
Procedure notes transforaminal epidural steroid injection left L4-5 and L5-S1 09/15/10,  
10/27/10 and 05/04/11  
Evaluation MD 02/23/11  
Designated doctor evaluation 09/30/10  
Orthopedic comprehensive consultation 04/14/11  
Emergency physician record 10/28/11  
Designated doctor evaluation, MD 06/09/11  
Designated doctor evaluation MD 09/19/11

#### **PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female whose date of injury is xx/xx/xx. Records indicate she injured her left knee and lumbar spine while she was getting clothes out from rack when she slipped on floor doing open split. The patient has undergone previous left knee arthroscopic surgery with medial meniscectomy performed 09/10/09. A repeat left knee arthroscopy was performed on 02/12/10. Records indicate the claimant complained of back pain and bilateral leg pain left greater than right. MRI of lumbar spine on 07/21/10 revealed mild loss of normal signal at L4-5 with posterior central herniated disc measuring 5.16 mm with thecal sac impingement. There is mild posterior central disc protrusion at L5-S1. Electrodiagnostic testing reported evidence of acute left L4-5 lumbar radiculopathy. The claimant underwent a series of transforaminal epidural steroid injections with 50-60% temporary relief of symptoms. Lumbar discogram was performed on 10/17/11 and reported severe and concordant pain at L4-5 and L5-S1 with atypical and nonconcordant pain at L3-4. A contested case Decision and Order dated 01/13/12 determined that the compensable injury extends to include lumbar spine herniated nucleus pulposus (HNP) at L4-5, disc protrusion at L5-S1 and radiculopathy at the L4-5 level. The claimant was seen by Dr. on 02/21/12 with back pain and bilateral leg pain, worse on left. Dr. noted the claimant evidently won her CCH hearing on 01/13/12. He last saw the patient in 09/10. She was noted to have HNP at L4-5 and L5-S1 with clinical instability at L5-S1 only. The claimant was recommended to undergo surgical intervention.

A request for 1 day length of stay for L4-5-S1 laminectomy, discectomy; L5-S1 arthrodesis with cages, posterior was non-certified as medically necessary per utilization review findings dated 03/01/12. It was noted the claimant slipped in shower while helping a client and did splits twisting her left knee and falling on her bottom. She had medications, extensive physical therapy, epidural steroid injections, psychotherapy, and continues with symptoms. MRI on 07/21/10 notes L2-4 normal, L4-5 5 mm disc with no mention of root involvement and L5-S1 mild central disc protrusion. On 10/17/11 discogram noted abnormal disc at L3-S1 and "concordant pain at L4-S1 and pain at L3-4." On 09/28/10 Dr. stated EMG noted L4 and L5 radiculopathy on left but study notes only left L4-5 radiculopathy. His exam notes positive

straight leg raise on left, decreased ankle jerk on left, weakness of gastroc and quads on left, and paresthasias on L5 and S1 levels on left. On 02/21/12 Dr. notes decreased ankle reflexes on left, paresthasias on L5 and S1 on left and weakness of EHL, anterior tib, and gastroc on left without atrophy. Dr. had asked for 2 day LOS for L4-S1 laminectomy and L5-S1 arthrodesis with cage that was denied. The current request is for 1 day LOS for L4-S1 lumbar laminectomy, discectomy and L5-S1 arthrodesis with cage. It was noted the claimant does not meet guidelines. Exam findings are not consistent over time with each other with EMG/NCV and MRI findings. It is noted the MRI study is over two years old and out of date for reference. It showed minimal degenerative changes at multiple levels and none with nerve root involvement. It was noted all pain generators are not identified. The discogram and levels requested for surgery do not correlate. No instability has been documented on radiographs. No psychological evaluation or smoking history is provided. Therefore, medical necessity is not established.

An appeal request was reviewed on 03/08/12 and the previous non-authorization was upheld. It was noted that despite conservative treatment the claimant still complains of low back and left greater than right leg pain. On examination straight leg raise is positive at 45 degrees bilaterally, left ankle jerk is diminished, and there is weakness of left TA, gastroc and EHL. Diagnostic studies include EMG done 09/28/10 showing evidence of L4-5 nerve irritation. MRI scan 07/21/10 shows an L5 disc protrusion with central 5mm L5 disc herniation. A discogram done 10/17/11 shows non-concordance of the L3-4 disc with concordance at both L4 and L5. The request for discectomy/decompression with posterior cages and fusion L4-S1 (question PLIF or TLIF) was previously denied on 02/29/12. The reviewer noted that for a previous denial to be overturned Official Disability Guidelines requires objective evidence to support substantial change in the employee's medical condition. That is lacking in the above request. In addition the reviewer mentioned that discogram is not felt to be a reliable indicator of either disc pathology or fusion success (carry). Also the requesting physician uses the term functional spinal unit collapse as an indicator of spinal instability. Reviewer noted unfamiliarity with the term but it appears to simply be disc space collapse which is not an indicator of spinal instability. For the above reasons the denial continues.

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

Based on the clinical information provided, the request for three day length of stay for L4-L5-S1 lumbar laminectomy, discectomy; L5-S1 arthrodesis with cages, posterior is not indicated as medically necessary. The claimant sustained an injury to the left knee and low back on xx/xx/xx. She underwent arthroscopic knee surgery times two. She continues to complain of low back pain with pain radiating to the left greater than right lower extremity despite conservative treatment including medications, physical therapy, epidural steroid injections and psychotherapy. An MRI performed 07/21/10 revealed L4-5 mild loss of normal signal, posterior central herniated disc measuring 5.16mm, and thecal sac impingement. At L5-S1 there is mild posterior central disc protrusion. EMG performed 07/30/10 and interpreted 08/18/10 reported evidence of acute left L4-5 lumbar radiculopathy. The claimant underwent lumbar discogram on 10/17/11; however, there is no negative control level as there was non-concordant pain at L3-4 with concordant pain reported at L4-5 and L5-S1. Moreover it is noted that current evidence based guidelines do not support the use of discography as a pre-operative indication for lumbar fusion. The claimant underwent individual psychotherapy with most recent treatment progress note dated 12/29/11 which indicated this to be number five of six approved individual psychotherapy sessions. There is no subsequent pre-operative evaluation indicating that the claimant was cleared for surgery from a psychological perspective. As noted on previous reviews, there is no objective evidence of instability of the lumbar spine at any level. As such the proposed surgical procedure with inpatient stay times three days is not supported as medically necessary.

**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)