

SENT VIA EMAIL OR FAX ON
Apr/12/2012

Independent Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (817) 349-6420
Fax: (817) 549-0311
Email: rm@independentresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/12/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior lumbar interbody fusion L4/5, posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation and 2 inpatient days

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 dated 04/03/12

Utilization review determination dated 02/24/12

Utilization review determination dated 03/12/12

Radiographic report lumbar spine 09/13/11

MRI lumbar spine dated 10/04/11

Clinic note Dr. dated 11/22/11

EMG/NCV study 12/16/11

Designated doctor evaluation dated 01/10/12

Clinic note Dr. dated 01/23/12

Presurgical psychological evaluation dated 02/17/12

Chiropractic treatment notes

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have sustained work related injuries to her low back on xx/xx/xx. Radiographs of lumbar spine performed on 09/13/11 are unremarkable. Subsequent MRI on 10/04/11 is unremarkable from T12-L1 through L3-4. At L4-5 there is broad protrusion slightly more focal to left and paracentral measuring approximately 1.9 cm in transverse diameter and 3 mm in AP diameter. There is moderate to severe facet

arthropathy with fluid in both joints. There is moderate spinal stenosis with subarticular recess narrowing and mild bilateral foraminal stenosis. At L5-S1 there is no disc protrusion. There is mild facet arthropathy. The radiologist notes a grade I anterolisthesis of L4 on L5.

On 11/22/11 the claimant was seen by Dr.. At this time the claimant complains of pain in low back, left shoulder and left knee. It is reported she slipped and fell on some water. She is reported to have received conservative treatment. Current medications include Hydrocodone 10 mg and Amitriptyline 10 mg. On physical examination the claimant is noted to have paraspinal tenderness at L4-5, decreased range of motion, tenderness over left knee and shoulder with decreased range of motion. Straight leg raise is 80 degrees on left and 90 degrees on right. Facet loading tests are negative. Deep tendon reflexes are normal bilaterally. Gait is within normal limits. Sensory is decreased in left lower extremity in L4-5 distribution. Motor is reported to be decreased in left L4-5 distribution. The claimant was subsequently recommended to undergo lumbar epidural steroid injection. On 12/16/11 the claimant underwent EMG/NCV study which was positive for left S1 radiculopathy.

On 01/10/12 the claimant was seen by Dr., designated doctor. She notes the claimant complains of left shoulder pain, low back pain, and left knee pain worse with standing than sitting. Without medications pain is 8/10. On physical examination she is 5'4" and weighs 189 lbs. She walks with slow deliberate gait. She is in no acute distress. She can sit without difficulty. She reported being unable to walk on toes because it hurts her back. She has no tenderness over lumbar spine. She has paraspinal muscle spasm in lumbar region, no trigger points. Range of motion is decreased. Supine straight leg raise is positive bilaterally. Seated and cross legged straight leg raise are negative. She has history of thoracic outlet surgery in 1989. Range of motion is decreased in all planes of left shoulder. Range of motion appears decreased in left knee. Reflexes are 2+ and symmetric. Sensory is normal in all 4 extremities. Motor examination is normal in all 4 extremities. She is opined to be at clinical maximum medical improvement with 5% whole person impairment and opined to be able to return to work at sedentary level occupation.

On 01/23/12 the claimant was seen by Dr.. The claimant is reported to have complaints of low back pain radiating into left lower extremity and she reported occasional radiation from right knee to foot. She is status post physical therapy without improvement. Current medications include Hydrocodone and Amitriptyline. Physical examination indicates she is 5'4" 188 lbs. Lumbar range of motion is restricted secondary to pain and body habitus. Motor examination is 4/5 in left tibialis and left EHL otherwise 5/5 throughout. Reflexes are 2+ and symmetric. She is reported to have had difficulty with heel walking but less with toe walking. She exhibited difficulty with tandem gait. Straight leg raise was positive on left at 60 degrees and negative on right. She is reported to have hypoesthetic region to pinprick and light touch on left along distribution of S1 nerve root. The claimant was subsequently recommended to undergo an anterior lumbar interbody fusion at L4-5 with fixation with posterior lumbar decompression posterolateral fusion and pedicle screw instrumentation at L4-5. The claimant was referred for pre-operative psychiatric evaluation on 02/17/12 in which it was felt that the claimant was a good candidate for the proposed procedure.

The initial request was reviewed by Dr. on 02/24/12 who non-certified the request noting that the record only mentions injections being recommended and not that there were actually performed. He further notes that EMG showed an S1 radiculopathy and the request is for surgery at the L4-5 level.

A subsequent appeal request was reviewed by Dr. on 03/12/12 who subsequently non-certified the appeal request noting that there's no evidence of instability demonstrated. She notes that MRI showed moderate spinal stenosis at L4-5 without significant foraminal stenosis. She notes that if the patient was symptomatic from her moderate spinal stenosis she would have bilateral leg symptoms which she does not. She notes her left lower extremity symptoms through history does not correlate with MRI. She subsequently non-certified the appeal request.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

The request for anterior lumbar interbody fusion at L4-5, posterior lumbar decompression with posterolateral fusion pedicle screw instrumentation and two day inpatient stay is not supported as medically necessary. The submitted clinical records report that the claimant sustained injuries to her low back as a result of a slip and fall. The record notes that there is a grade 1 anterolisthesis at L4 on L5 with broad based protrusion with facet arthropathy resulting in moderate spinal stenosis and mild foraminal narrowing. The record contains absolutely no data to establish that this motion segment is unstable. The record does not contain flexion or extension views which indicate that there's greater than 4.5mm of translation and it would further be noted that the claimant has undergone EMG/NCV study which is indicated the presence of an S1 radiculopathy however there's no disc protrusion or significant pathology identified at this level. The record does not indicate that the posterior elements have been eliminated as potential pain generator and there is no indication that the claimant has undergone lumbar epidural steroid injections to address the radicular symptoms corroborated by EMG/NCV dated 12/16/11. It would further be noted that on 01/10/12 the claimant was seen by Dr. a designated doctor who reports no significant findings on physical examination. The claimant's reflexes are 2+ her sensory examination is normal. Her motor examination is normal. Yet when seen by Dr. on 01/23/12 13 days later the claimant is reported to have 4/5 strength in the left tibialis anterior and EHL. She's reported to have difficulty with heel walking but less with toe walking yet on her designated doctor evaluation she reports she's unable to walk on her toes because it hurts her back to do so. She's reported to have a hypoesthetic region to pin prick and light touch along the distribution of the S1 nerve root which was not appreciated on the designated doctor evaluation. There is a clear lack of correlation or clear lack of consistency between examinations 13 days apart. Based upon the submitted clinical records the claimant does not meet criteria per Official Disability Guidelines and clearly would be a poor surgical candidate based on the inconsistencies in the clinical record. Therefore the prior utilization review 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)**