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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/30/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

inpatient transforaminal lumbar interbody fusion at L4-5 with three day inpatient stay

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

M.D., Board Certified 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. The reviewer finds that medical necessity does not exist for inpatient transforaminal lumbar interbody fusion at L4-5 with three day inpatient stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO dated 07/09/12
Utilization review determination dated 05/23/12
Utilization review determination dated 06/25/12
Clinical records Dr. 07/25/11-07/05/12
MRI lumbar spine dated 08/15/11
MRI thoracic spine dated 08/15/11
Procedure report lumbar epidural steroid injection 10/25/11
EMG/NCV 01/30/12
Clinic note Dr. dated 03/19/12-05/09/12
Radiographic report lumbar spine 05/07/12
MRI lumbar spine 07/16/12
MRI thoracic spine 07/17/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who is reported to have sustained work related injuries on xx/xx/xx. On date of injury he was unloading refrigerator by himself and placing it on the ground when he felt sharp painful pop in his low back. The claimant was seen at xxxxxxx for evaluation. He came under the care of Dr. on 07/25/11. He was provided oral medications including Lortab and Medrol DosePak. On physical examination he has midline lumbar tenderness, no bony abnormalities, bilateral paraspinal spasm and tenderness. Sacroiliac joints are nontender. Flexion is to ground, extension from flexed position is limited due to pain. He has negative straight leg raise bilaterally. He was subsequently provided prescriptions for Amrix and Lortab. He was recommended to perform stretching exercises. On 08/15/11 he was referred for MRI of lumbar spine and thoracic spine. MRI of lumbar

spine showed 2 mm degenerative anterolisthesis at L4 on L5 with left synovial facet cyst projecting anteriorly from facet joint into left neural foramen / extraforaminal region measuring 7 mm x 8 mm medial to lateral. This may be affecting dorsal root ganglion and or exiting left L4 nerve root. At T12-L1 there is central right paracentral disc protrusion measuring 2 mm AP x 2 cm medial to lateral which narrows the right lateral recess and may be affecting the traversing right L1 nerve root. There is mild facet arthropathy at L3-4 and L5-S1. There are Schmorl's nodes at T12-L1 inferior endplate at L5. On 10/25/11 the claimant had a lumbar epidural steroid injection at L4-5 on the right.

On 01/30/12 the claimant was referred for EMG/NCV study. This was normal and showed no evidence of lumbar radiculopathy. On 02/28/12 the claimant was seen by Dr.. She reported concern over new symptoms of intermittent anesthesia and urinary hesitancy. She recommends referral to neurosurgery. The claimant was prescribed Lyrica.

On 03/19/12 the claimant was seen by Dr.. He is reported to have progressively escalating low back pain with radiation into right greater than left legs. He denies any bowel or bladder dysfunction. Pain is made worse by prolonged standing, walking, and forward flexion of lumbar spine. He is reported to have undergone several lumbar injections, which have not provided any relief. Physical examination indicates the claimant is 6 feet inches tall and weighs 156 lbs. Motor strength is 5/5. Reflexes are 2/4 and symmetric. Gait is normal. It was opined the claimant has acquired spondylolisthesis. He is to be referred for lumbar flexion / extension films. This study dated 05/07/12 showed no evidence of instability. The claimant was seen by Dr. on 05/09/12 at which time he opines the claimant has severe low back and leg pain due to segmental instability. He is reported to have 1 mm anterolisthesis of L4 on L5, which increases to 9 mm when standing. The claimant was subsequently referred for repeat imaging studies on 07/16/12. Study of lumbar spine showed right paracentral disc protrusion of T12-L1 of 3-4 mm posteriorly displacement with effacement of thecal sac and extension to medial aspect of neural foramen. This measured 3-4 mm and was reported to measure 2 mm on previous exam. There is canal narrowing at T12-L1 of 40-50%. There are fairly moderate degenerative disc changes at T12-L1, mild degenerative disc disease at L3-4, moderate degenerative disc disease at L4-5, lateral recess stenosis at L3-4 and L4-5, grade I spondylolisthesis of approximately 6 mm previously measuring 7 mm, canal stenosis of 50-60% at L4-5. There is edematous change along right posterolateral elements of L5 seen compatible with stress reaction to right pedicle. There is fairly moderate to severe facet arthropathy at L4-5. The initial request was reviewed on 05/23/12 by Dr.. Dr. non-certified the request noting there is no clear documentation of condition or diagnosis for which fusion is indicated such as instability or statement that decompression will create surgically induced instability and subsequently non-certified the request. The appeal review was performed by Dr. on 06/25/12. He non-certified the request noting that the request was previously denied due to lack of clear documentation of condition and diagnosis for which fusion is indicated such as instability or statement that decompression will create surgically induced instability. He notes there is no clear documentation of recent comprehensive clinical evaluation from provider or treating physician that addresses the proposed surgery. He noted no specific evidence of lumbar spine instability or radiculopathy in the lower extremities. He notes that there are no documented motor deficits in the affected spinal levels including positive provocative tests. He notes that there is no evidence of instability on flexion extension radiographs and electrodiagnostic studies are normal. He further finds that there is no recent psychological evaluation submitted for review.

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

The submitted clinical information indicates that the claimant has a history of low back pain with radiation to the bilateral lower extremities. There are some inconsistencies noted in the claimant's clinical record as it is reported that he developed saddle anesthesia, yet there are no documented findings on physical examination. It would additionally be noted that lumbar flexion extension radiographs showed no evidence of instability and EMG/NCV study showed no evidence of radiculopathy. Based on this information alone the claimant would not be a candidate for the requested procedure per the Official Disability Guidelines. It is additionally noted that the claimant has not been referred for a pre-operative psychiatric evaluation to

address any potentially confounding issues, which could impact the claimant's recovery. Based on the totality of the clinical information, the reviewer finds that medical necessity does not exist for inpatient transforaminal lumbar interbody fusion at L4-5 with three day inpatient stay.

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)