

IRO Express Inc.

An Independent Review Organization

2131 N. Collins, #433409

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Dec/21/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4/5 L5/S1 Posterior Fusion with crosslinks to previous fusion removal of existing hardware and posterior decompression with 3 days LOS

A 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Cover sheet and working documents

Office visit notes 07/01/11-08/11/11

Office visit notes 08/11/11

Operative report 11/21/11

Operative report 11/30/11

Physical therapy initial examination 01/25/12

MRI lumbar spine 07/20/12

Peer review report 10/04/12

X-ray lumbar spine 2 views 10/16/12

Lumbar spine series flexion/extension views 10/16/12

Behavioral medicine evaluation 11/26/12

Utilization review determination 09/18/12

Utilization review determination 11/07/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained an injury to the low back. He lifted and developed immediate pain in the low back radiating down into his legs. The claimant had a history of a previous discectomy performed in 2008. After failing a course of conservative care, the claimant underwent lumbar laminectomy with posterior lumbar interbody fusion at L5-S1 and L4-5 on 11/21/11. He participated in post-operative physical therapy and remained symptomatic despite post-operative care, including therapy and medications. Examination dated 08/17/12 reported severe pain with range of motion; tenderness to palpation in both sacroiliac joints, right greater than left; left straight leg raise; decreased sensation on the anterior top of the thighs as well as posterior calves. MRI of the lumbar spine dated 07/20/12 revealed post-surgical changes at L4-5 and L5-S1. At L5-S1, there was a small right paracentral focal disc protrusion causing minimal right subarticular recess narrowing, and mild left neural foraminal narrowing. At L4-5, there was a shallow broad based central left paracentral disc osteophyte complex without significant stenosis. Enhancing granulation tissue was noted in the left laminectomy bed extending into the left lateral epidural space and left subarticular recess surrounding the left L5 nerve root. Multilevel degenerative changes of the remaining lumbar levels were also noted, with no significant stenosis at these levels. X-rays of the lumbar spine on 10/16/12 revealed post-operative changes of left laminectomy and fusion at L4-5 and L5-S1, with some progressive disc space narrowing at L4-5 with greater exposure of the superior aspect of the stabilizing rod at L4 compared to prior exams from 12/15/11 and 03/30/12 which changed in degree with flexion extension, suggestive of settling and/or movement. A pre-surgical psychological screening was completed on 11/26/12 and determined the claimant to be clear for surgery with a fair to good prognosis.

A pre-authorization request for L4-5-S1 posterior fusion with crossed links to previous fusion and removal of existing hardware and posterior decompression of right side with three day length of stay was denied per review dated 09/18/12 which noted there was no evidence of lumbar instability, spondylolisthesis, or pseudoarthrosis of the prior fusion. There was no indication of migration of hardware, and no diagnostic hardware block had been performed for decompression of the right side. Without objectified pathology, right sided decompression was not medically indicated. It was further noted that the claimant was not stated to have any neurological or motor deficits to either of the lower extremities. There was a positive left straight leg raise test. There had not been any exhaustion of lower levels of care such as diagnostic epidural steroid injections. The claimant had used medications and undergone limited physical therapy. As such, the requested surgical procedure was not certified as medically necessary.

A reconsideration request for L4-5, L5-S1 posterior fusion with crossed links to previous fusion and removal of existing hardware and posterior decompression of right side with three day length of stay was denied per pre-authorization review dated 10/22/12. The reviewer noted that the lumbar x-ray report on 09/25/12 documenting a 5mm movement of the superior part of the rod at L4 was not submitted and there was no evidence that a psychological evaluation had been done. As such, the medical necessity of the request was not established. It was further noted that the request for posterior decompression was not established as the claimant reported leg weakness, but no objective findings corroborating L4-5 and L5-S1 radiculopathy were documented.

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

The claimant sustained a lifting injury to the low back on 06/17/11. He underwent left laminectomy and posterior interbody fusion at L4-5 and L5-S1 on 11/21/11. He participated in post-operative physical therapy and was treated with medications, but remained symptomatic. Imaging studies revealed post-operative changes at L4-5 and L5-S1, but there was no indication of hardware failure or of pseudoarthrosis at any level of the lumbar spine.

Lumbar x-rays including flexion extension views revealed post-operative changes with some progressive disc space narrowing at L4-5. Stabilizing rod superiorly at L4 showed greater exposure compared to prior exams which changed in degree with flexion extension, suggestive of settling and/or movement, but no visible breakage of hardware was seen. There was no quantification of the extent of movement on flexion extension views. There was no indication that the claimant had exhausted lower levels of care, including epidural steroid injections. There was no indication on physical examination of motor or sensory changes corresponding to the relevant nerve root distribution. Based on review of the clinical information provided, it is the opinion of the reviewer that the proposed surgical procedure of L4-5 and L5-S1 posterior fusion with cross links to previous fusion and removal of existing hardware and posterior decompression with three day length of stay 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)