

SENT VIA EMAIL OR FAX ON
Jan/06/2012

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Jan/06/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
L4-5-S1 Laminectomy Discectomy Fusion Instrumentation Implantable Bone Growth Stimulator LOS X 2

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
Notification of determination 12/15/11
Appeal review determination 12/23/11
Office notes MD 11/29/11
MRI scan review MD 11/30/11
Psychological evaluation PhD 01/11/11
Progress notes DO 09/09/11 through 11/21/11
Procedure note epidural steroid injection 10/21/11 and 09/20/11
Procedure note lumbar facet medial branch block 06/15/11
MRI lumbar spine 09/01/11
Electrodiagnostic results 10/08/09
Carrier submission law offices of JD including documents for consideration and reference materials 01/03/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is xx/xx/xx. The records indicate he was injured when a xx backed over his right lower leg resulting in fracture to the tibia and fibula. He complains of low back pain and bilateral leg pain right worse than left. Records indicate the claimant has been treated conservatively with physical therapy, exercise program, chiropractic care and epidural steroid injections which have not adequately alleviated his pain. He is status post right ankle and foot reconstruction with right tibial intermedullary rod and ankle arthrodesis. MRI of the lumbar spine dated 09/01/11 revealed transitional S1-S1 segments. There is an inferiorly extruded broad based disc herniation at L4-5 with abutment of both L5 nerve roots in the lateral recesses. At L5-S1 there is a broad based disc herniation with moderate compression of both S1 nerve roots in the lateral recess and mild impression both L5 nerve roots in the neural foramina. Electrodiagnostic testing performed 10/08/09 reported evidence of a right L5 radiculopathy. There is also concern for a right S1 radiculopathy. Claimant was seen for surgical consultation on 11/29/11. It was noted that the claimant has had psychological clearance for surgery with Dr.. Physical examination at that time reported positive spring test L4-5 and L5-S1, positive extensor lag, positive sciatic notch tenderness, bilaterally, although a little bit worse on the right, negative foot and finger test. There was positive flip test bilaterally, positive Lasegue's on the left at 45 degrees and on the right at 60 degrees, positive Braggard's on the left, unable to do Braggard's on the right because of ankle fusion. He has absent ankle jerk on the left, absent posterior tibial tendon jerks bilaterally and hypoactive knee jerk on the left. He has gastrocnemius weakness on the left. On the right he is unable to plantar flex because of ankle fusion. He has paresthesias in the L5 and S1 nerve root distribution of both left and right. Claimant was recommended to undergo surgery with two level decompressive lumbar laminectomy, discectomy and instrumented arthrodesis with reduction of subluxation with internal bone growth stimulator.

A pre-authorization review dated 12/15/11 determined the request for L4-5-S1 laminectomy discectomy fusion instrumentation implantable bone growth stimulator LOS times two as not medically necessary. Records note the claimant sustained multiple injuries as a result of work place event. The claimant is noted to have sustained significant trauma to the right lower extremity. He has a history of chronic back pain that is unremitting. Per clinic note dated 11/29/11 Dr. reports the claimant has functional spine unit collapse at L4-5 from normal of 16mm to collapse with 5 with total changes of 11mm associated with posterior column deficit, facet subluxation and foraminal stenosis. He again reports functional spine unit collapse from 16mm to 4mm for total change of 12 in posterior column deficit. He opines this establishes instability. The record does not include any independent radiographs, nor does it include independent lumbar flexion/extension radiographs that establish instability at L4-5 and L5-S1 level. Records indicate the claimant clearly has pathology that would be amenable to simple decompression. However the data as provided does not establish medical necessity for performance of fusion procedure at these levels.

A pre-authorization review dated 12/23/11 determined the appeal request for L4-5-S1 laminectomy discectomy fusion instrumentation implantable bone growth stimulator LOS times two as not medically necessary, and the previous denial was upheld.

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

Based on the clinical data provided, medical necessity is not established for the proposed two level lumbar decompression and fusion with instrumentation and implantation of bone growth stimulator with two day inpatient stay. The claimant is noted to have sustained an injury on xx/xx/xx. He complains of ongoing low back pain radiating to the right greater than left lower extremity. MRI of the lumbar spine revealed L4-5 extruded broad based disc herniation with abutment of both L5 nerve roots in the lateral recesses, and at L5-S1 broad based disc herniation with moderate compression of both S1 nerve roots in the lateral recess and mild depression of both L5 nerve roots in the neural foramina. EMG reported evidence of a right L5 radiculopathy and concern for right S1 radiculopathy. The claimant underwent

conservative treatment including physical therapy, epidural steroid injections and facet blocks without resolution of symptoms. A psychological evaluation on 01/11/11 cleared the patient for surgery from a psychological perspective. However as noted on previous review, there is no objective evidence of motion segment instability of the lumbar spine. While it appears that surgery for simple decompression of the nerve roots of L4-5 and L5-S1 would be appropriate, medical necessity is not established for the proposed instrumented fusion. As such the previous denials should be 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)