

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

inpatient L4-5 and L5-S1 posterior lumbar decompression and fusion with three (3) days length of stay (LOS)

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

M.D., Board Certified Neurological Surgery

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

Official Disability Guidelines
Notice of utilization review findings 03/22/12
Notice of utilization review findings 04/04/12
New patient office note Dr. 03/06/12
MRI lumbar spine 01/31/12
Lumbar spine x-rays with flexion/extension views 02/10/12
Psychological evaluation 03/28/12
Appeal letter 04/17/12
discharge instructions 04/08/12
Office visit Dr. 03/14/12
Physical therapy initial evaluation and plan of care 03/05/12
Physical therapy discharge summary 03/13/12
Urinalysis / drug screen 02/24/12
Office notes 07/14/11-02/14/12
Consult / history and physical Dr. 02/21/12
MRI lumbar spine 06/16/11
Office visit notes NP 06/06/11 and 06/10/11
Previous utilization review determinations 01/03/12, 12/01/11, 10/21/11, 10/11/11
Physical therapy initial evaluation and plan of care 07/26/11
Physical therapy daily note 07/27/11-08/16/11
Physical therapy discharge summary 08/16/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who was injured while removing a box full of store reports from her car. She has history of L5-S1 left laminectomy in 2008. She presents with complaints of low

back pain and left leg pain and weakness. The patient was seen by Dr. on 03/16/12. She has had 9 months of low back pain axial in nature and left lower extremity radiculopathy. She has had falls recently and pain and numbness going down left leg and weakness in foot. She has tried a variety of conservative treatment including physical therapy. She is now on her second round of physical therapy without improvement. She has had 2 epidural steroid injections without relief. She had foraminal injection on left that gave her several days of relief but then pain returned. She has been using anti-inflammatories and pain medications and muscle relaxants. She has no right leg symptoms. She has history of prior lumbar microdiscectomy L5-S1. She continues to smoke tobacco. On physical examination the claimant is 64 inches tall and 125 lbs. She has diminished light touch in L5 distribution on left leg. She has absent ankle jerk on left. Gait and station reveals antalgic gait. Muscle bulk and tone is normal.

Motor strength is 5/5 in all major muscle groups of upper and lower extremities except 4+/5 in dorsiflexion on left. Straight leg raise is positive on left. MRI of lumbar spine performed on 01/31/12 revealed postoperative changes at L5-S1. Previously described large disc extrusion is no longer visualized. There is no evidence of recurrent disc herniation. There is narrowing of disc space with marginal disc osteophyte complex and mild bilateral facet degeneration producing mild bilateral foraminal narrowing. At L4-5 there are degenerative changes with minimal bilateral facet degeneration and thickening of ligamentum flavum producing mild stenosis of lateral recesses bilaterally as well as minimal central canal stenosis and mild left foraminal narrowing. Radiographs of lumbar spine on 02/10/12 revealed degenerative changes. There is small calcification overlying posterior left mid abdomen, possibly renal calculus similar to prior exam of 09/11/08. There is no evidence of subluxation on flexion/extension of lateral views. Degenerative changes are present in both SI joints. The patient underwent psychological evaluation on 03/29/12 and was determined to be psychiatrically cleared to undergo spinal fusion or any other medical intervention deemed medically necessary and/or appropriate.

Per notice of utilization review findings dated 03/22/12, non-authorization was recommended for inpatient posterior lumbar decompression and fusion at L4-5 and L5-S1 with 3-day length of stay. History includes previous L5 discectomy in 2008 from which she apparently made good recovery until present illness. She complains of back and left lower extremity pain aggravated by prolonged standing or sitting and has failed conservative treatment including physical therapy and epidural steroid injections x 2. On examination straight leg raise was positive on left. There is diminished left ankle jerk (most likely related to previous surgery); however, there is hyperesthesia of L4 dermatome and slight dorsiflexion weakness on left. MRI scan done on 01/31/12 showed degenerative changes with mild stenosis at L4-5 with significant degeneration with disc space narrowing at previously operated L5 level. There is no evidence of degeneration with disc space narrowing at previously operated L5 level. There is no evidence of recurrent disc herniation. Flexion / extension x-rays done 02/10/12 showed no evidence of instability. The reviewer noted the patient appeared to fulfill diagnosis of mechanical low back pain as there is no radiological evidence of instability; however, she is lacking psychosocial screening. It is noted the claimant is a smoker and for two level fusion is important smoking be stopped prior to surgery. Per notice of utilization review findings dated 04/04/12, non-authorization was recommended for reconsideration request for inpatient L4-5 and L5-S1 posterior lumbar decompression and fusion with 3 day length of stay. The original decision was upheld. The reviewing physician noted the claimant was injured on 06/02/11 when removing a box full of store reports from her car. She initially complained of back and leg pain. The claimant has previously undergone surgery at L5-S1 in 2008. She has had epidural steroid injections and foraminal injections with limited improvement. MRI of lumbar spine performed on 01/31/12 showed degenerative changes, but no indication of traumatic pathology. X-rays dated 02/10/12 showed degenerative changes and no instability of the spine. There was psychological evaluation that deemed the claimant a candidate for the requested surgery. Official Disability Guidelines recommendation indicates there be radiologic evidence of instability. The claimant is also a smoker and necessary for this to be stopped prior to performing surgery. Therefore, the reviewer agreed with previous reviewer and upheld denial.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

The claimant is noted to have sustained a lifting injury to her low back. She has history of previous surgery at L5-S1 in 2008. She currently complains of low back pain radiating to left lower extremity. MRI of lumbar spine performed on 01/31/12 revealed postoperative changes at L5-S1 with no abnormal enhancement of thecal sac or nerve roots and no evidence of recurrent disc herniation. At L4-5 there are degenerative changes producing mild lateral recess stenosis bilaterally and minimal central canal stenosis with mild left neural foraminal narrowing. X-rays of lumbar spine on 02/10/12 revealed degenerative changes without evidence of motion segment instability on flexion / extension views.

The patient is noted to have failed conservative treatment including physical therapy, medications, and epidural steroid injections. On examination performed 03/06/12 the claimant was noted to have diminished sensation to light touch in L5 distribution of left leg. Left ankle jerk was absent. Motor strength was 4+/5 in dorsiflexion on left. Straight leg raise was positive on left. The claimant was cleared for surgery from psychological perspective; however, noting there is no evidence of spondylolisthesis or instability of lumbar spine at any level, the ODG criteria for this surgery have not been satisfied. Therefore, the reviewer finds the proposed inpatient L4-5 and L5-S1 posterior lumbar decompression and fusion with three (3) days length of stay (LOS) is not indicated 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)