

I-Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/12/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

360 minimally invasive lumbar fusion at L4-L5 and L5-S1

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

M.D., Board Certified 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

Official Disability Guidelines

Request for IRO 02/24/12

Utilization review determination 01/05/12

Utilization review determination 01/25/12

MRI of the Lumbar spine dated 02/23/11

Clinical records Dr. dated 04/20/11, 06/15/11, 08/24/11, 12/14/11, 01/12/12, 01/24/12

Urine Drug Screen dated 05/18/11

Physical Therapy Treatment Records

Clinical Records Dr. dated 05/18/11, 06/01/11, 06/15/11, 07/08/11, 08/05/11, 11/04/11, 01/20/12

Procedure Report dated 06/02/11, 08/18/11

Functional Capacity Evaluation dated 08/23/11

Designated Doctor Evaluation dated 09/07/11

Psychiatric Evaluation dated 10/05/11

Clinical Records Dr. dated 11/14/11

Report of Lumbar discography dated 11/23/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is reported to have sustained work related injuries on xx/xx/xx as a result of lifting heavy boxes. She is reported to have received conservative treatment with physical therapy and a Medrol DosePak. On physical examination dated 09/12/10 she is noted to have a left small test for back pain and a right slump test for back pain. MRI was reported to be consistent with an L4-5 radiculopathy and epidural steroid injection was recommended. Her symptoms were relieved with pain medication (hydrocodone) and there was mild improvement on Lyrica. She underwent lumbar laminectomy on 11/24/10 at L4-5 and L5-S1 with subsequent discectomy. She had continued complaints of pain and was seen by Dr. on 10/20/11. He suggested that the claimant may require fusion. She was initiated on a conservative treatment program of physical therapy and core stabilization exercises. On 10/05/11 she was referred for psychological evaluation and was cleared for surgery. Records

indicate the claimant has undergone conservative treatment, which consisted of oral medications, physical therapy, epidural steroid injections and has undergone discography.

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

This claimant has a history of minimally invasive microdiscectomy at L4-5 and L5-S1. She has had continued low back pain with radicular symptoms that has been unremitting. She has undergone extensive conservative treatment, which has included oral medications, physical therapy, and LESI. The claimant had lumbar discography, which indicated concordant pain at the L4/5 and L5/S1 levels with appropriate negative control discs. She has been cleared for surgery from a psychological perspective. She has failed exhaustive conservative care without improvement. Imaging and discography have clearly established the presence of axial back pain attributable to the L4/5 and L5/S1 levels. Based on the exhaustion of conservative management and clear identification of the primary pain generators, the reviewer finds there is a medical necessity for 360 minimally invasive lumbar fusion at L4-L5 and L5-S1.

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)