

I-Decisions Inc.

An Independent Review Organization
5501 A Balcones Drive #264
Austin, TX 78731
Phone: (512) 394-8504
Fax: (207) 470-1032
Email: manager@i-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/05/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient L2-3, L3-4 ALIF/PISF With Bilateral L3/4 Re-exploration Laminectomy / Discectomy

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

M.D., Board Certified Orthopedic Surgeon, Spine Surgeon

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 medical necessity is not established for Inpatient L2-3, L3-4 ALIF/PISF With Bilateral L3/4 Re-exploration Laminectomy / Discectomy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Radiographs lumbar spine dated 04/17/06
MRI lumbar spine dated 06/20/06
Procedure notes dated 07/14/06-03/03/11
CT lumbar spine 07/12/12
MRI lumbar spine 04/30/12
Electrodiagnostic studies 07/30/09
Clinic note from Sport 08/15/11-08/06/12
Prior reviews dated 07/30/12-08/15/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who has been followed for long history of low back and lower extremity pain. The patient is status post L3-4 laminectomy in 2006 and electrodiagnostic studies from xxxx suggest possible L5 radiculopathy. The patient has been treated at Sport as of xx/xx after his low back pain was exacerbated by carrying boxes. Clinic note on xx/xx/xx reported numbness in lower extremities and feet. His medications included Norco and Soma. Physical examination was not reported and patient was continued on prescription medications. Additional MRI studies were recommended in 03/12 due to continuing right lower extremity numbness and right lower extremity weakness. MRI of lumbar spine dated 04/30/12 revealed degenerative foraminal stenosis at L2-3 greater to right with facet

arthropathy causing anatomic impingement on exiting right L2 nerve root. Bulging was present; however, no disc herniation was identified at L2-3. At L3-4 facet arthropathy, spondylolisthesis, and annular bulging caused marked degree of canal stenosis with anatomic impingement on the exiting L3 nerve roots bilaterally worse to the right. Dr. opined on 05/29/12 that MRI study showed degree of arachnoiditis contributing to bilateral foot numbness. No in depth physical examination at this visit was reported. CT of lumbar spine dated 07/12/12 revealed severe intervertebral disc space narrowing at L2-3 and L3-4 with endplate sclerosis seen along the end plates. Bilateral facet hypertrophy was noted throughout the lumbar spine and prior laminectomy changes at L3, L4 and L5 were noted. Clinical evaluation on 08/06/12 stated the patient continues to have low back pain despite medications. There was no history of smoking. No physical examination was reported.

The request for L2-3 and L3-4 anterior lumbar interbody fusion with posterior fixation and bilateral L3-4 reexploration laminectomy, discectomy was denied by utilization review on 07/30/12 as there was no evidence of clinical evidence of instability at L2-3 or L3-4 to warrant operative intervention. There is no evidence of progressive neurologic deficit. The request was again denied on utilization review on 08/15/12 as there is insufficient evidence regarding lumbar radiculopathy without evidence of clinical instability and lack of psychological screening as recommended by guidelines.

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

There is insufficient clinical documentation to establish diagnosis of lumbar radiculopathy. No in depth physical examinations were submitted for review that identified severe progressive neurologic deficit. The CT evaluation revealed degenerative disc disease at L2-3 and L3-4; however, no clinical instability was identified. There is also minimal clinical documentation regarding recent conservative treatment other than medication management. It is unclear whether the patient has reasonably exhausted other lower levels of care such as physical therapy or further injections. There is no psychological evaluation submitted for review addressing possible confounding issues as recommended by current evidence based guidelines. The clinical documentation submitted for review does not meet ODG recommendations for the requested surgical procedures. The reviewer finds medical necessity is not established for Inpatient L2-3, L3-4 ALIF/PISF With Bilateral L3/4 Re-exploration Laminectomy / Discectomy.

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 KNOWLEDGBASE
- 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)