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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/14/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: inpatient LOS 2 days posterior lumbar interbody fusion @ L4-5 w/instrumentation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for an inpatient LOS 2 days posterior lumbar interbody fusion @ L4-5 w/instrumentation is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Mental health diagnostic testing dated 01/07/11
Clinical note dated 12/07/11
X-rays of the lumbar spine dated 06/13/12
MRI of the lumbar spine dated 06/19/12
Electrodiagnostic studies dated 10/24/12
Clinical notes dated 11/01/12, 11/15/12, 12/27/12, 01/03/13, 02/21/13, 03/28/13, 05/30/13, 05/31/13, 06/25/13, 07/10/13, 07/18/13, 09/05/13, 09/12/13, & 09/13/13
Functional capacity evaluation dated 07/25/13
Behavioral assessment dated 01/11/13
Adverse determination dated 09/18/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his low back. The x-ray of the lumbar spine dated 12/07/11 revealed degenerative joint disease with a grade 1 spondylolisthesis of L4 over L5. The x-ray of the lumbar spine dated 06/13/12 confirmed the anterior listhesis of L4 over L5 by 8mm. A hypertrophic spur formation was noted on the left at L2-3. The MRI of the lumbar spine dated 06/19/12 revealed degenerative findings at the L4 and L5 levels. A left sided posterolateral neuroforaminal radial annular tear was noted at L3-4. The electrodiagnostic studies completed on 10/24/12 revealed indications of an acute irritability in the L3 through S1 motor roots. The clinical note dated 01/03/13 indicates the patient complaining of a loss of control of both bowel and bladder. The patient also stated this was noted to be progressively worsening. The patient rated his pain as high as 8/10 at that time. The patient was noted to have significant difficulty rising from a sitting position. The patient was noted to have a positive straight leg raise bilaterally at 30 degrees. A loss of sensation was noted on the left

in the L5 and S1 distributions. Reflex deficits were noted at both ankles. The behavioral evaluation dated 01/11/13 indicates the patient being recommended for a surgical intervention. However, the patient was further recommended for postoperative treatment as the patient was noted to have high expectations of the surgical outcome. The clinical note dated 03/28/13 indicates the patient utilizing a lumbar corset as well as the use of a cane for ambulatory assistance. Upon exam, the patient was able to demonstrate 20 degrees of lumbar flexion and 10 degrees of extension. Limitations were further noted with lateral bending and rotation. The note does mention the patient utilizing Zanaflex, Lortab, and Elavil for pain relief.

The clinical note dated 05/31/13 indicates the patient continuing with severe complaints of pain in the low back with associated muscle spasms and stiffness. Decreased sensation was noted in the L4 and L5 distributions bilaterally. Decreased reflexes continued at the ankles and knees. The clinical note dated 07/25/13 indicates the patient stating the initial injury occurred when he felt a pop in the back resulting in a tremendous amount of pain. The patient was recommended for a surgical intervention at that time. The progress note dated 09/13/13 indicates the patient having undergone a chronic pain management program.

The previous utilization review dated 09/18/13 indicates the patient having been denied the request for a posterior lumbar interbody fusion at L4-5 with instrumentation and a 2 day inpatient stay secondary to no information regarding the patient's psychological symptoms. No information was submitted regarding the patient's completion of a chronic pain management program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient complaining of low back pain with associated loss of sensation and reflexes in the lower extremities. A fusion would be indicated in the lumbar region provided the patient meets specific criteria to include completion of all conservative measures and the patient is noted to have undergone a psychosocial evaluation addressing any confounding issues. There is minimal information regarding the patient's completion of all conservative measures addressing the low back complaints. It appears the patient initiated a chronic pain management program in September of 2013. However, no information was submitted regarding the patient's completion of the CPMP. As such, it is the opinion of the reviewer that the request for an inpatient LOS 2 days posterior lumbar interbody fusion @ L4-5 w/instrumentation is not recommended 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)