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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
Apr/03/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
L4/5 L5/S1 open Transforaminal lumbar interbody fusion with 3 day inpatient stay

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO 03/25/13
Receipt of request for IRO 03/26/13
Utilization review determination 03/11/13
Utilization review determination 03/21/13
Clinical record 06/19/12 and 02/14/13
MRI cervical spine without contrast 07/10/12
Designated doctor evaluation 09/18/12
Designated doctor evaluation 12/03/12
MRI lumbar spine 11/13/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who sustained multiple injuries as result of a slip and fall on xx/xx/xx. The claimant had chronic cervical pain with radiation to the upper extremities, low back pain, and wrist pain. Per the clinical note dated 06/19/12, MRI showed degenerative disc changes at L4-5 and L5-S1. There was only minimal stenosis. reported that he was recommending surgery consisting of an L4-5 and L5-S1 fusion as an absolute last resort. She had a one and a half month history of frequent urination and possible bowel and bladder incontinence. She reported having severe pain in her back and left leg. She was managing her symptoms with Naprosyn and Flexeril. The claimant was subsequently recommended to undergo repeat imaging studies.

MRI of the cervical spine dated 07/10/12 noted prominent disc herniations at C4-5, C5-6, and C6-7.

The claimant was seen by a designated doctor on 09/18/12. had previously seen the claimant. He reported a diagnosis of tendinitis of the left wrist which improved with treatment, lumbar disc herniation at L5-S1 on the left, and ruled out radiculopathy on the left. He noted that her treatment consisted of visits for medications which included Flexeril and Naproxen. She was seen at the and was told that she would probably need surgery. He noted that the claimant had been seen who suggested that she would be a candidate for lumbar fusion at L4-5 and L5-S1. On physical examination, she was 5'5" tall and weighed 204 pounds and she appeared uncomfortable. No notable findings were documented and it was noted that the claimant was somewhat reluctant to bear weight on the left lower extremity. There was no tenderness of the lumbar spine. Lumbar range of motion was mildly reduced and she was reported to have an antalgic somewhat staggering type gait. She was unable to stand on her toes or heels. She was unable to squat or perform a deep knee bend. Reflexes were considered a trace to 1+ and it was reported that there was decreased sensation over the left L5 distribution. The claimant was opined to have lumbar disc herniations at L4-5 and L5-S1 with reported evidence of radiculopathy on the left. It was recommended that the claimant continue to receive treatment and she should be seen by a neurosurgeon in consultation and he recommended additional imaging studies.

The claimant was referred for repeat MRI of the lumbar spine on 11/13/12 which noted spondylosis, degenerative endplate changes, disc space narrowing, degenerative disc disease, broad based posterior disc bulge/disc protrusion with disc extrusion, facet arthropathy, moderate right neural foraminal narrowing, and mild left neural foraminal narrowing, and mild spinal stenosis at L4-5 and at L5-S1 there were degenerative endplate changes and disc space narrowing, degenerative disc disease, broad based posterior disc bulge protrusion, facet arthropathy, mild right neural foraminal narrowing, and moderate left neural foraminal narrowing.

The claimant was seen in follow up on 12/03/12.

On 02/14/13, the claimant was seen in follow up and at this time the claimant had continued complaints of numbness, pain, and paresthesias in her left upper extremity extending to her fingertips. She was referred for MRI of the cervical spine and lumbar spine and she returned for follow up and she was reported to have continued severe back pain and bilateral lower extremity pain on the left greater than the right and it was reported that the cervical MRI showed kyphosis. The claimant was subsequently recommended to undergo ACDF at C4-5, C5-6, and C6-7 with performance of a TLIF and lumbar fusion at L4-5 and L5-S1.

On 03/11/13, the initial request was reviewed. The evaluator non-certified the request, noting that the claimant does not meet ODG criteria for transforaminal lumbar interbody fusion or a lumbar decompression. The reviewer notes that there must be evidence of radiculopathy, corresponding imaging findings demonstrating neurocompressive lesions, documentation of failure of conservative treatment. He notes that the performance of fusion for chronic low back pain is not supported by ODG or current clinical studies. The reviewer finds no clinical evidence of lumbar radiculopathy. He further notes that imaging reports failed to demonstrate dynamic segmental instability or spondylolisthesis. He notes that flexion/extension views were not obtained and there was no psychological clearance made available for review.

The appeal request was reviewed on 03/21/03. The appeal reviewer concurs with the initial review. He finds no evidence of any motion segment instability, severe disc space collapse, or severe spondylolisthesis that would reasonably support a L4-5 and L5-S1 lumbar interbody fusion. The reviewer further finds that no psychological evaluation was submitted for review which demonstrated that the patient had reasonable expectations for the requested surgery and ruled out any confounding issues which could impact postoperative recovery. He further notes that the most recent MRI revealed a perineural cyst at the level of S2 which may be consistent with Tarlov cyst. He notes that this finding has not been ruled out as a potential pain generator. The evaluator subsequently upholds the prior denial.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The records indicate that the claimant is a d female who sustained injuries as a result of a slip and fall. The submitted clinical records suggest that the claimant has received conservative management consisting of oral medications and physical therapy. The record contains no data which establishes that the claimant has undergone interventional treatments. There is no current data suggesting that the claimant has undergone facet injections to rule out the posterior elements as potential causes of pain. The claimant's physical examination has been benign and shows no evidence of a progressive neurologic deficit. There is a clear lack of correlation between imaging studies and physical examination findings. The record does not include a pre-operative psychological evaluation as mandated by ODG. Therefore, it is the opinion of this reviewer that the request for L4-5 and L5-S1 TLIF with a 3-day inpatient stay cannot be supported as medically necessary and the prior utilization review determinations are 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)