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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/02/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Inpt LOS x3 L4-5 TLIF w/decom discectomy 63030 22612 22630 22851 22840

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 this reviewer that medical necessity for the requested Inpt LOS x3 L4-5 TLIF w/decom discectomy 63030 22612 22630 22851 22840 has not been established

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a xx year old male who sustained an injury to his low back when he was pulling a cable connected to a trailer. Per clinical note dated xxxxx. the patient presented with low back pain. The patient noted radiating pain into the left hip and occasionally to the knee. Numbness and tingling were also noted in the left buttocks with a burning sensation. The note details the patient having undergone a lumbosacral x-ray which revealed no instability on flexion/extension views. The MRI of the lumbar spine dated 10/31/12 revealed canal stenosis and left greater than right foraminal narrowing at L4-5 related to a broad-based disc protrusion. Per clinical note dated 11/12/12, the patient rated his low back pain as 3-6/10. Upon exam, tenderness to palpation was noted at the left SI joint. The patient demonstrated 5 degrees of lumbar extension. The psychological evaluation dated 01/31/13 details the patient being endorsed for surgical intervention in the lumbar region. Per clinical note dated 01/07/13, the patient rated his low back pain as 7-8/10. The note details the patient having initiated physical therapy at that time. The patient was also noted to be utilizing Norco and Ibuprofen for ongoing pain relief.

The previous utilization review dated 01/15/13 resulted in a denial secondary to the patient's lack of completion of conservative treatments, failure to complete a psychological evaluation, and no evidence of radiculopathy or nerve root impingement on diagnostic imaging.

The utilization review dated 03/04/13 also resulted in a denial secondary to a lack of evidence of the patient's radiculopathy on physical examination, failure to complete all conservative measures, and the absence of spinal instability on radiographs.

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 ongoing low back pain. The Official Disability Guidelines recommend fusion and decompression in the lumbar spine provided the patient meets specific criteria to include significant findings noted in the appropriate distribution, x-rays confirming instability, and completion of all conservative measures. No information was submitted regarding the patient's completion of a full course of physical therapy. Additionally, the submitted clinical notes detail the patient having undergone x-rays which revealed no instability. Furthermore, the specific request is for a L4-5 fusion. No information was submitted regarding the patient's specific radiculopathy complaints noted in the L4 or L5 distributions. Therefore, this request does not meet guideline recommendations. As such, it is the opinion of this reviewer that medical necessity for the requested Inpt LOS x3 L4-5 TLIF w/decom discectomy 63030 22612 22630 22851 22840 has not been established and the prior denials 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

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)