

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Aug/02/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

COSA Left Side L5-S1 Microendoscopic Decompression

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

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical note dated 12/23/10

MRI of the lumbar spine dated 04/02/12

CT myelogram of the lumbar spine dated 04/26/12

MRI of the lumbar spine dated 06/03/12

Clinical reports dated 04/28/11 – 07/15/13

Prior reviews dated 06/27/13 & 07/09/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx and has been followed for complaints of low back and radicular pain to the right lower extremity. Prior treatment has included epidural steroid injections and medial branch blocks. MRI studies of the lumbar spine from 04/02/12 identified PARS fractures at L4 and L5. CT myelogram studies of the lumbar spine completed on 04/26/12 showed slight impression of the thecal sac at L5-S1 secondary to a broad based disc herniation without compression or displacement of the S1 nerve roots. There is an addendum for this report indicating that both S1 nerve root sleeves were filled with contrast and there was abutment of the right S1 nerve root within the lateral recess. The patient was noted to have short term relief from epidural steroid injections only. Medications have included the use of anti-inflammatories. Updated MRI studies of the lumbar spine completed on 06/03/13 demonstrated mild loss of the disc height at L5-S1 with a 2.5mm disc bulge without foraminal or canal stenosis. The clinical report on 06/07/13 stated the patient continued to have low back pain radiating to the left lower extremity without

improvement. Physical examination demonstrated a decreased sensation in a left L5-S1 dermatome. recommended decompression at L4-5 to the left side. The most recent evaluation on 07/15/13 continued to show bilateral weakness at the extensor hallucis longus with 1+ reflexes at the Achilles. There was loss of range of motion on extension.

The L5-S1 lumbar decompression was denied by utilization review on 06/27/13 as it was unclear what level the patient was actually being recommended for in regards to decompression and imaging studies failed to identify canal or foraminal stenosis at either L4-5 or L5-S1.

The request was again denied by utilization review on 07/09/13 as the patient's complaints and exam findings did not correlate with imaging.

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

The patient has been followed for ongoing complaints of low back pain radiating to the left lower extremity per the recent clinical reports submitted for review. The patient's objective findings and subjective complaints are not consistent with the imaging studies submitted for review. The most pertinent finding was the addendum of the 2012 CT myelogram study which identified possible abutment of the right S1 nerve root within the lateral recess. There were no left sided findings noted on imaging that would reasonably account for the patient's subjective complaints or noted objective findings. No further diagnostic testing such as electrodiagnostic studies were submitted for review and given the non-correlating findings on physical examination as compared to imaging studies, it is this reviewer's opinion that medical necessity for the proposed L5-S1 discectomy is not established at this time per guideline recommendations.

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)