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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/04/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Intra operative monitoring during surgery

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 Intra operative monitoring during surgery is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO dated 01/11/13
Receipt of request for IRO dated 01/14/13
Utilization review report dated 12/28/12
Utilization review determination dated 12/31/12
Utilization review report dated 01/10/13
Utilization review determination dated 01/10/13
MRI lumbar spine dated 11/16/11
Peer review dated 01/30/12
Peer review dated 01/31/12
Addendum peer review dated 02/03/12
Clinical note dated 02/22/12, 07/27/12, 09/26/12
Radiographic report of the lumbar spine dated 02/22/12
MRI lumbar spine dated 08/17/12

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a female who sustained injuries to her low back on xx/xx/xx. On this date, she is noted to have been employed when she developed low back and leg complaints. The claimant is noted to be 5'6" tall and weighs 230 lbs. She was reported to have pain localized to the right lower extremity with positive tension sign. Her reflexes are depressed in the right ankle. Motor strength in intact in both EHLs and patellar tendon reflexes are intact. The claimant received conservative treatment consisting of oral medications and physical therapy. MRI dated 11/16/11 notes a central protrusion at L5-S1 with foraminal compromise. There are disc bulges at L3-4 and L4-5. Records indicate

that the claimant was trialed on multiple medications without substantive relief. She subsequently is reported to have undergone EMG of the lower extremities which was reported as normal. The record includes a MRI of the lumbar spine dated 08/17/12. This study notes a central right paracentral disc protrusion at L5-S1 with narrowing of the lateral recess and impingement of the right L5 nerve root which could account for a right L5 radiculopathy if present clinically. There are mild disc bulges and protrusions at L2-3, L3-4, and L5-S1. The most recent clinical note is dated 09/26/12. The claimant is noted to have severe right leg pain radiating down the posterolateral aspect of the right leg. It is reported that current anterior strength is 5-, current left hip anterior strength is 5, and current left EHL peroneus strength is 5-. Current right EHL peroneus strength is 5, current left gastroc soleus strength is 5, and current right strength is 5. Left knee reflex is hypoactive. It is opined that the claimant has a lumbar disc herniation on the right at L4-5 with positive straight leg raise. She is reported to have failed conservative care. She subsequently has been recommended to undergo a microdiscectomy on the right at L4-5.

The initial review was performed on 12/28/12. non-certifies the request for intraoperative monitoring. He notes that intraoperative monitoring is recommended during spinal intracranial surgeries when such a procedure has a significant risk of complications. He notes that there is a lack of information regarding the potential for complications in the patient's impending surgery.

A subsequent appeal request was reviewed. non-certified the request noting that elective intraoperative monitoring is not the standard of care. He notes that there is no complexity while performing a microdiscectomy that would require intraoperative monitoring. As such, he opines that the records do not support the request.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The submitted clinical records indicate that the claimant has low back pain with radiation into the right lower extremity that is refractory to conservative management. Records strongly suggest that the claimant is a surgical candidate. However, the requested procedures of a simple laminectomy, decompression, and discectomy would not require intraoperative monitoring. This is a routinely performed surgery with only limited risk of iatrogenic injury. The tolerances in the lower lumbar spine are far more forgiving than that of the cervical spine where intraoperative monitoring is clinically indicated. Further, the record does not indicate or provide data to suggest that the claimant physiologically has increased risk for injury that would warrant the use of intraoperative monitoring. The prior utilization review determinations were appropriate and consistent with the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for Intra operative monitoring during surgery 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)