

US Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/21/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: IP: lumbar laminectomy/fusion/instrumentation at L4-5 with LOS x 1 63042-50, 63044-50 post-op DME: TLSO back brace purchase L0464

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D Board Certified Neurosurgery

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 IP: lumbar laminectomy/fusion/instrumentation at L4-5 with LOS x 1 63042-50, 63044-50 post-op DME: TLSO back brace purchase L0464 has not been established and the prior utilization review determination shall be upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Request for IRO, undated

Receipt of request for IRO dated 11/30/12

Utilization review determination dated 10/16/12

Utilization review determination dated 11/05/12

Operative report dated 08/10/10

Discharge summary dated 08/11/10

Clinical records dated 09/02/10, 03/03/11, 04/07/11, 06/08/11, 07/18/11, 09/19/11, 12/15/11, 01/19/12, 02/23/12, 03/22/12, 04/23/12, 05/21/12, 06/19/12, 07/26/12, 08/27/12, and 10/08/12

MRI lumbar spine dated 04/28/11

CT myelogram of lumbar spine dated 06/03/11

MRI lumbar spine dated 08/24/12

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a male who is reported to have a date of injury of xx/xx/xx. The claimant is reported to have sustained an injury to his low back as a result of jumping. He was noted to have severe left radicular leg pain with a foot drop secondary to a large left L4-5 disc extrusion. On 08/10/12, the claimant was taken to surgery and underwent a left L4-5 laminectomy and decompression on the L4 and L5 nerve roots with performance of a discectomy. Postoperatively, he had no complications and he was noted to have had improvement in his leg pain. Records indicate that on 04/07/11 the claimant

reportedly developed recurrent left lower extremity radiculopathy. He is noted to have pain in the dorsum of his foot as well as weakness on left great toe dorsiflexion. MRI of the lumbar spine was performed on 04/28/11. This study notes facet joint effusions at L1-2, L2-3, and L3-4. There is no evidence of disc herniation, canal stenosis, or neural foraminal encroachment at L1-2, L2-3, or L3-4. At L4-5 there are post-surgical changes. At L-S1 there is a broad 2 mm disc bulge. The claimant underwent CT myelography of the lumbar spine on 06/03/11. This study notes mild narrowing of the L4-5 disc. There was no evidence of abnormal translation. It is reported that there are bilateral pars defects at L5. When seen in follow-up on 06/08/11, reports that flexion/extension views during myelography did not show any evidence of instability. It is reported that there are bilateral pars defects at L5-S1. On 09/19/11, it was recommended that the claimant undergo surgical intervention consisting of a posterior L4-5 decompression, fusion, and instrumentation. The claimant's medications included Motrin and Ambien as well as narcotic medications. Additional diagnostic studies were ordered and these appear to have been denied by utilization review. A repeat MRI dated 08/24/12 notes a degenerative disc at L4-5 with bilateral neural foraminal narrowing.

The initial review was performed on 10/16/12. non-certified the request noting that the record contains multiple letters. He noted that there were no clinical notes submitted for review with a comprehensive physical examination. He noted that the clinical record does not document evidence of what conservative modalities the patient had exhausted prior to the requested surgical intervention. He noted that the physician's description of the pathology is not consistent with the submitted imaging study. As such, he non-certified the request.

The appeal request was reviewed on 11/05/12. non-certified the request. She noted that the clinical notes provided do not contain evidence of which conservative treatments have been exhausted prior to the surgical request. She noted that there is insufficient clinical documentation to indicate the necessity of this request. She subsequently upheld the prior utilization review determination.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical record provides insufficient data to establish that the claimant meets ODG criteria for the requested procedure. The record provides no data to establish that there is instability at the L4-5 level. The submitted clinical notes do not detail the claimant's conservative management; therefore, there is no indication that the claimant has exhausted all conservative care. Additionally, the record does not include a preoperative psychiatric evaluation as required by Official Disability Guidelines. There appears to be a difference in interpretation of the MRI and imaging studies submitted. Therefore, it is the opinion of this reviewer that medical necessity for IP: lumbar laminectomy/fusion/instrumentation at L4-5 with LOS x 1 63042-50, 63044-50 post-op DME: TLSO back brace purchase L0464 has not been established and the prior utilization review determination shall be 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)