

IRO REVIEWER REPORT TEMPLATE -WC

Independent Reviewers of Texas

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Notice of Independent Review Decision

[Date notice sent to all parties]:

December 31, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Reconsideration of Forte's NON-AUTHORIZATION of inpatient one (1) day length of stay (LOS) for a lumbar laminectomy/discectomy on the right at L5-S1

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)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Employer's first report of injury or illness dated 04/16/12
2. Clinical note 04/09/12-05/22/12
3. MRI lumbar spine dated 04/23/12
4. Electrodiagnostic studies 05/22/12
5. Clinical note dated 11/07/12
6. Prior reviews dated 11/14/12 and 12/07/12

7. Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx when he slipped and fell landing on his back. The patient was initially evaluated on 04/09/12 with complaints of low back pain radiating to right lower extremity. At this point in time the patient was taking over the counter medications for pain and initial physical examination was unremarkable. It is noted the 04/09/12 clinical note is incomplete. The patient underwent MRI studies of lumbar spine on 04/23/12 which revealed a 6 mm right paracentral disc extrusion extending 8 mm below the disc level at L5-S1. There was displacement of right S1 nerve root posteriorly. No foraminal or central canal stenosis was identified. The patient reported ongoing numbness in right lower extremity and electrodiagnostic testing on 05/22/12 identified an acute denervation of right L5-S1 nerve root distribution. The patient denied any continued pain as of 05/22/12. The patient was referred on 11/07/12 with continued complaints of numbness in right lower extremity. The patient denied any conservative treatment to date. Physical examination at this visit revealed limited range of motion of lumbar spine on flexion, extension and lateral bending. There was some right toe flexion weakness noted and hypersensitivity was present in right lateral foot. The right Achilles reflex was absent at this evaluation. The patient was recommended for discectomy to right L5-S1.

The requested lumbar laminectomy, discectomy to right at L5-S1 was denied by utilization review on 11/14/12 as there was no documentation of conservative treatment.

The request was again denied by utilization review as there was no conservative treatment documented.

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

The requested L5-S1 right lumbar laminectomy, discectomy with 1 day inpatient stay is not recommended as medically necessary based on clinical documentation submitted for review. The patient indicated his pain resolved and only complained of ongoing numbness in right lower extremity. To date there has been no documentation regarding an adequate course of conservative treatment as recommended by current evidence based guidelines. There is no documentation the patient failed to improve with use of anti-inflammatories, physical therapy or epidural steroid injections as outlined by guidelines. Given the absence of any conservative treatment to date for the patient's symptoms, medical necessity was not established based on guideline recommendations.

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

x MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

xODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG Indications for Surgery™ -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

A. L3 nerve root compression, requiring ONE of the following:

1. Severe unilateral quadriceps weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps weakness
3. Unilateral hip/thigh/knee pain

B. L4 nerve root compression, requiring ONE of the following:

1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
3. Unilateral hip/thigh/knee/medial pain

C. L5 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
2. Mild-to-moderate foot/toe/dorsiflexor weakness
3. Unilateral hip/lateral thigh/knee pain

D. S1 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
3. Unilateral buttock/posterior thigh/calf pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

1. MR imaging
2. CT scanning
3. Myelography
4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following:

A. Activity modification (not bed rest) after patient education (\geq 2 months)

B. Drug therapy, requiring at least ONE of the following:

1. NSAID drug therapy
2. Other analgesic therapy
3. Muscle relaxants
4. Epidural Steroid Injection (ESI)

C. Support provider referral, requiring at least ONE of the following (in order of priority):

1. Physical therapy (teach home exercise/stretching)
2. Manual therapy (chiropractor or massage therapist)
3. Psychological screening that could affect surgical outcome
4. Back school (Fisher, 2004)