

IRO REVIEWER REPORT TEMPLATE -WC

IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

Date: 06/28/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Appeal OUTPT L5-S1 Lami/Disc 63030 23 OBS

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

Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

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. 01/17/2013, Progress note, MD.
2. 01/29/2013, MRI report of the lumbar spine, MD.
3. 01/29/2013, MRI review note, no stated provider.
4. 01/30/2013, Letter To Whom It May Concern, no stated provider, Orthopedic Associates.
5. 02/06/2013, Initial physical therapy evaluation, PT.
6. 02/06/2013, Daily physical therapy note, PT.

7. 02/12/2013, Procedure note, MD.
8. 02/12/2013, Injection procedure note for a transforaminal epidurogram, MD.
9. 02/25/2013, Progress note, MD.
10. 03/07/2013, Progress note, MD.
11. 03/07/2013, Correspondence, MD.
12. 03/07/2013, Correspondence to another provider, MD.
13. 03/11/2013, Internal correspondence for hand outs, (no credentials given), Back Institute.
14. 03/27/2013, Progress note, PA-C.
15. 03/28/2013, Internal correspondence with hand out, (no credentials given), Back Institute.
16. 04/25/2013, Behavioral Medicine Evaluation, PhD.
17. 04/26/2013, Emergency department records, Regional Medical Center.
18. 05/06/2013, Progress note, MD.
19. 05/16/2013, Progress note, MD.
20. 05/23/2013, Progress note, MD.
21. 04/08/2013, Utilization review determination, Mutual.
22. 05/10/2013, Utilization review determination, Mutual.
23. 06/14/2013, Correspondence regarding previous determinations, Mutual.

PATIENT CLINICAL HISTORY [SUMMARY]: This claimant is a female with complaints of back pain. On 01/17/2013, she was seen in clinic by MD for complaints of low back pain. She stated that she had pain that radiated down her left leg to the back of her knee at times. She reported being injured lifting during an in-service demonstration when she felt initial pain. She reportedly had undergone 6 sessions of physical therapy. Pain was rated at a 5. Physical examination revealed motor strength to be 5/5 throughout, Patellar reflexes were 2/4, and Achilles reflexes were 2/4. She had normal reflexes and distal sensation. Faber's test was positive bilaterally, and distraction test was positive bilaterally. X-rays were obtained, showing good disc spaces without fractures or spondylolisthesis. On 01/29/2013, an MRI of the lumbar spine was obtained, revealing at L5-S1, there was a central 5.1 mm disc protrusion that contacted both S1 nerve roots and at the thecal sac. There was no central canal or foraminal stenosis. The exam was read by MD. On 01/29/2013, a review of the MRI was performed by an unstated provider. On 01/30/2013, a letter To Whom It May Concern was submitted, indicating that she was scheduled to undergo surgery of the lumbar spine on an outpatient basis.

On 02/06/2013, this claimant was seen for an initial physical therapy evaluation by PT at Sports Medicine. On 02/06/2013, she was given physical therapy.

On 02/12/2013, this claimant was taken to surgery for a fluoroscopically-guided contrast-enhanced left S1 transforaminal epidural steroid injection by MD. On 02/25/2013, this claimant returned to MD for further evaluation. Pain was rated at

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7/10 at that time, and there was no radiation into the bilateral buttocks or the bilateral lower extremities. She stated that after any type of physical therapy activity, she was increasing pain. Upon examination, she had the ability to sit and stand without much discomfort. She had pain along the bilateral SI joints in the lower back. Otherwise, the exam was unchanged.

On 03/07/2013, the claimant was seen by MD for complaints of back pain. Upon examination, straight leg raise was positive on the right at 45 degrees, and she had pain with straight leg raise that was located at her back. Straight leg raise was positive on the left at 30 degrees. She had tenderness to palpation in the hip bursa bilaterally, and internal rotation and external rotation of the hips bilaterally produced pain. All muscle groups tested were rated at 3, and light touch was normal. X-rays demonstrated the iliac crest to be level, with the right hip slightly higher than the left, but there was no spondylolisthesis. There was slight L5 vertebral body lipping. On 03/07/2013, a letter was submitted to MD, detailing the clinical exam. On 03/07/2013, a letter was submitted to Dr., detailing the clinical visit by Dr.

On 03/27/2013, this claimant was seen in clinic by PA-C. This was for pain into both hips and the medial and lateral thighs. She denied having any numbness. She reported tingling across the low back. She had not had any bowel or bladder issues. Upon exam, reflexes were 2+ at the knees bilaterally and absent at the ankles bilaterally.

On 04/25/2013, the claimant underwent a Behavioral Medicine Evaluation by PhD. It was noted at that time that she was cleared for surgery with a good prognosis for pain reduction and functional improvement. On 04/26/2013, the claimant presented to the emergency room. She stated that she had pain that went into the right thigh and into the left thigh. She denied bowel or bladder dysfunction at that time. She denied sensory loss. Reflex exam revealed right patellar reflexes to be 2+ and the left patellar reflex to be 2+. She was given medication management at that time.

On 05/06/2013, the claimant returned to clinic with an evaluation by MD. At that time, she had pain with movement, and her gait was antalgic and slow. Her manual muscle testing was difficult to assess due to guarding. Achilles reflexes were 1+ bilaterally, and knee reflexes were 1+ bilaterally. On 05/16/2013, she returned to clinic with further evaluation by MD. She continued to report back pain. Upon examination, she had normal gait, but it was slow, and she had 5-/5 strength in all muscle groups tested into both lower extremities.

On 05/23/2013, she returned to MD for further evaluation. She continued to report pain to the back and leg pain located on the left side. She had complaints of axial low back pain as well as left-sided radicular and pseudoradicular complaints. She had a positive sitting root test and straight leg raise on the left. She had make/break type weakness and definite weakness with plantar flexion, left side worse than the

right. Surgical intervention was recommended.

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

On 04/08/2013, a utilization review determination was that the requested service, outpatient L5-S1 laminectomy and discectomy, was non-certified. It was noted that the MRI revealed no central bulge contacting both S1 nerve roots and the thecal sac; and therefore the current clinical presentation did not clearly correlate with the MRI findings to support the requested L5-S1 laminectomy and discectomy. A subsequent review on 05/10/2013 also considered the requested service, L5-S1 laminectomy and discectomy, as non-certified. It was noted that the clinical notes evidenced the claimant presenting with global weakness not in a myotomal pattern. She had a straight leg raise primarily for back pain and not leg pain. Additionally, it was noted that she had had no relief with an epidural steroid injection; and at least in the anesthetic phase, relief would be expected. Therefore, the request for an appeal for an outpatient L5-S1 laminectomy and discectomy was non-certified. The additional records provided for this review include the MRI of the lumbar spine dated 01/29/2013. This exam revealed that there was a central 5.1 mm disc protrusion that contacted both the S1 nerve roots and the thecal sac, and there was no central canal or foraminal stenosis. The records do indicate that she received a steroid injection on 02/12/2013; and when she returned to clinic on 02/25/2013, she reported that she got no pain relief from the transforaminal epidural steroid injection and that actually, pain had increased after that injection. It is important to note that on the clinical exam of 05/16/2013, she had 5-/5 make/break strength in all groups tested in the lower extremities. It was further noted that actual palpation of her pulses caused leg pain. A further, subsequent clinical note of 05/23/2013 indicated that she was re-examined at that time and continued to have pain. It was noted that at that point, she had 3/5 to 4/5 strength in the plantar flexors on the left, 4/5 strength in the EHL on the left and a positive sitting root test. With the new information that revealed that she has marked decreased strength rated at 3/5 to 4/5 on the left, the claimant is a candidate for surgical intervention at this time.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES