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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

May/1/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient open 360 L4-S1 with 2 days length of stay

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

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. The patient initially sustained abrasions on the right forearm and right lower extremity. The patient reported ongoing complaints of low back pain. MRI of the lumbar spine on 09/13/12 identified disc desiccation at L4-5 and L5-S1 with facet joint hypertrophy contributing to right neural foraminal stenosis. At L5-S1, there was disc space narrowing with disc bulging and facet hypertrophy contributing to bilateral neural foraminal narrowing. No evidence of canal stenosis was noted. Primary conservative treatment included the use of muscle relaxers. The patient completed a physical therapy program through 11/12. The patient was evaluated at the XXXX on 09/18/12 with complaints of low back pain radiating to the right lower extremity. The patient reported weakness in the bilateral lower extremities. Physical examination at this visit demonstrated mild weakness in the right and left tibialis anterior and

bilateral extensor hallucis longus and peroneals. Right gastrocnemius strength was also mildly reduced. There was an absent right knee reflex reported. The patient was recommended for selective nerve root blocks at L4-5 and L5-S1. Pain medications including Norco were continued. The patient had electrodiagnostic studies on 10/12/12 which revealed evidence of a mild subacute right L5 radiculopathy. Follow up on 10/31/12 indicated that the patient was not significantly improving with physical therapy. Physical examination reported a positive right straight leg raise. The patient underwent right L4 epidural steroid injection on 01/02/13. Follow up on 02/05/13 indicated that the patient had no improvement of symptoms with the injection. Physical examination was limited with no significant finding reported. Follow up with on 02/06/13 stated the patient had progressive weakness in the right lower extremity with an antalgic gait. Physical examination findings at this visit were unchanged since the 09/12 exam. Extensive decompression was planned for the right L5 facet which would require lumbar fusion to prevent iatrogenic instability. The patient underwent behavioral medicine evaluation on 02/26/13. The patient reported that he was not a smoker at this visit. BAI findings were at 18 indicating mild to moderate anxiety. The patient scored a 10 on the common opioid misuse measurement indicating a significant likelihood of opioid medication abuse. The patient was cleared for psychological evaluation and cleared for surgery from a psychiatric standpoint. The request for an L4 through S1 lumbar fusion was denied by utilization review on 06/08/13 as there was no evidence of instability that would warrant a fusion procedure. There was also no psychological screen provided. The request was again denied by utilization review on 03/19/13 indicating that the patient was not a good candidate for the procedure due to continuous pain that was not relieved by rest. There was no evidence of mechanical instability in the lumbar spine. Given the EMG findings reported of L5 radiculopathy, the requests would not directly address.

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

From the clinical documentation submitted for review, the patient has had unremitting low back pain radiating to the right lower extremity since the date of injury. This has not improved with conservative management, including use of medications physical therapy or injections. The patient has electrodiagnostic evidence of a mild L5 radiculopathy and physical examination revealed bilateral lower extremity weakness with reflex changes. On review of the MRI report, there was no evidence of any significant disc space narrowing spondylolisthesis or motion segment instability. No flexion/extension views of the lumbar spine were performed. Per the clinical records the patient is being recommended for decompression with facet joint revision to an extent that would cause iatrogenic instability. However, it is unclear why extensive facetectomies are being planned. There is no indication from the imaging study that there is severe lateral recess stenosis at the L4-5 or L5-S1 level that would really reasonably warrant an extensive facet resection therefore causing iatrogenic instability. It is also unclear whether the pain generators have been effectively identified. Per the clinical record, the patient reported no response to the epidural steroid injection at L4-5. Given the inadequate response to injections, it is clear that pain generators in this patient have not been accurately identified. Therefore, post-operative outcomes for a lumbar fusion of this extent would be known. Additionally, there are concerns regarding psychological evaluation. No extensive evaluation of the patient occurred. There was no validity testing through MMPI-2 studies that would rule out any areas of confounding issues that would impact post-operative recovery. The patient reported mild to moderate anxiety which was not confirmed through MMPI-2 testing. The patient also scored a significant severity level on the opioid misuse test indicating that the patient would most likely abuse opioids in a post-operative condition. For multiple reasons noted above, the requested lumbar fusion from L4 to S1 would not be supported as medically necessary. As such, it is the opinion of this reviewer that the request would not be supported as medically necessary and the prior denials are 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)