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An Independent Review Organization

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Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

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)

Description of the service or services in dispute:

L3-5 minimally invasive anterior posterior fusion with bone graft and instrumentation

Patient Clinical History (Summary)

The patient is a female who sustained an injury on xx/xx/xx when she slipped and fell sustaining an injury to the right hip, right knee, and right ankle. The patient did require surgical repair of the right ankle to include reconstruction in March of 2013 followed by extensive physical therapy. The patient has also been followed for complaints of low back pain with associated numbness and tingling radiating to the right foot. Treatment has included the use of Norco for pain. The patient was noted to be allergic to anti-inflammatories. There was no indication of any recent injections or physical therapy. MRI studies of the lumbar spine from 05/22/14 noted a disc protrusion at L3-4 with advanced facet arthropathy and ligamentum flavum thickening resulting in mild to moderate canal stenosis with mild foraminal narrowing. At L4-5, there was grade 1 spondylolisthesis with facet hypertrophy contributing to severe narrowing of the canal with moderate foraminal stenosis. A grade 1 spondylolisthesis was also evident at L3-4. Electrodiagnostic studies from 06/05/14 noted evidence of a probable right L5-S1 radiculopathy. The patient was followed for surgical considerations. The clinical report from 09/04/14 noted continuing complaints of low back pain radiating to the right lower extremity that worsened with any standing or walking. The patient had difficulty walking more than 100 yards at a time. The patient reported no benefit from prior physical therapy, medications, or bracing. The patient's physical exam noted a listing to the left with a mild step off present in the L4-5 region to palpation. No other neurological findings were identified. Per report the recommendation was for an L3 to S1 minimally invasive anterior to posterior fusion with interbody spacers instrumentation and iliac crest bone graft. There was a psychological evaluation from 11/10/14 which found no contraindications to surgical intervention. The requested L3 to L5 minimally invasive anterior to posterior fusion with bone grafting and instrumentation was denied on 10/23/14 as there were no specifics regarding conservative treatment or documentation regarding psychological clearance. The request was again denied on 11/17/14 as there was lack of instability at one of the levels requested and no documentation regarding prior physical therapy or injections.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

In review of the clinical documentation submitted the patient has noted ongoing symptoms consistent with neurogenic claudication. The patient indicated that she had difficulty ambulating more than 100 feet at a time or performing any prolonged standing activities. MRI studies of the lumbar spine did note

moderate to severe spinal canal stenosis at L3-4 and L4-5 due to a grade 1 spondylolisthesis as well as facet hypertrophy. The patient reported no substantial benefit from prior physical therapy or medications. The psychological evaluation found nothing to support the need for additional counseling or further evaluation prior to surgery. This would address the prior reviewer's concerns. The MRI studies did show moderate to severe canal stenosis and with the amount of facet arthritis present at L3-4 and L4-5 it is highly unlikely in this case that the patient would be able to decompress adequately without creating iatrogenic instability at either level. Therefore stabilization of the anterior to posterior fusion with bone grafting and instrumentation would be required to avoid any iatrogenic instability from occurring which would require surgical intervention. Therefore it is this reviewer's opinion that the proposed procedures do meet medical necessity and guideline recommendations. Therefore, the prior denials are overturned.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPH-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and Guidelines European Guidelines for Management of Chronic Low Back Pain
- Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)