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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Aug/05/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

2 to 3 day inpatient stay for a lumbar re-do decompression right side anterior posterior fusion at L5/S1 and purchase of a post-operative back brace

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

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury on xx/xx/xx. The patient was followed for continuing complaints of right lower extremity symptoms and low back pain. The patient had prior partial laminectomy to the right from L4 through S1 with lateral recess decompression and decompression of the right L5 and S1 nerve roots on 11/14/11. Post-operatively the patient had continuing complaints of right sided lower extremities symptoms and recommended the continuation of Lyrica due to extensive epidural fibrosis. The patient had epidural steroid injections at L4-5 and L5-S1 to the right which provided some improvement in regards to symptoms however the patient had residual pain and numbness in the right lower extremity. Electrodiagnostic studies from 02/21/13 noted evidence of chronic irritation of the right L5 nerve root consistent with radiculopathy. CT myelogram of the lumbar spine from 02/20/13 noted moderate facet arthrosis at L4-5 to the right side with mild arthrosis to the left. There was hypertrophy of the facet capsule to the right mildly effacing the right thecal sac. No central canal or lateral recess stenosis was identified at L4-5. At L5-S1 there was moderate facet arthrosis with appearance of auto fused right sided facet. No central canal or lateral recess stenosis was identified. There was moderate mild to moderate right and mild left neural foraminal stenosis with subtle effacement of the right L5 nerve root. The patient had been recommended for revision decompression to the right at L5-S1 followed by fusion of the L5-S1 motion segment to formally fuse the facet joints given the auto fusion apparent on CT myelogram. The patient developed left lower extremity symptoms in 04/13. Updated imaging of the lumbar spine was done on 05/01/14. Flexion/extension views of the lumbar spine noted minimal narrowing of the in articular facets from L4 through S1. No instability

was identified on flexion/extension views. MRI of the lumbar spine on 05/01/14 noted mild broad based disc protrusion at L4-5 with facet arthropathy contributing to mild canal foraminal stenosis. Similar findings at L5-S1 were noted without evidence of spinal canal stenosis and bilateral and mild bilateral neural foraminal stenosis with facet arthrosis. Mild enhancing granulation tissue was identified posterior to L5. Post-operative changes were apparent at L4 at L5 and S1. The patient was seen on 05/22/14. The patient continued to utilize multiple medications including anti-inflammatories muscle relaxers and analgesics for pain. The patient continued to report right sided low back pain but denied any weakness or numbness in the lower extremities. On physical examination there was antalgic gait favoring the right lower extremity with marked weakness in the right foot. Tenderness over facet joints at L5-S1 was noted and paraspinal regions. Range of motion was limited in the lumbar spine. Weakness was reported at the right EHL consistent with L5 motor weakness. There was also weakness on right foot eversion consistent with S1 motor weakness. Sensation was decreased in the left lateral leg and dorsum of the left foot in the right lateral leg and dorsum of the right foot and sole of the right foot and posterior leg. Radiographs in office were reported to show facet joint enlargement to the lower lumbar spine from L4 through S1. The recommendation was for wide decompression at L5-S1 which would produce instability and require lumbar fusion procedures to prevent iatrogenic instability. The requested two to three day inpatient stay for lumbar redo decompression to the right with anterior to posterior lumbar fusion L5-S1 and purchase of post-operative lumbar brace was denied by utilization review on 07/02/14 as there were no official MRI records and radiographs of the lumbar spine identifying pathology that was contributing to reported symptoms. The request was again denied by utilization review on 07/14/14 as there was no evidence supporting spinal fusion including spinal instability or neural arch defect.

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

The patient has been continually followed for low back pain radiating to the right lower extremity. The most recent clinical records the patient continued to have weakness and sensory loss in the right lower extremity in L5-S1 distribution. There have been no clear improvements with conservative treatment. The most recent updated imaging studies of the lumbar spine including flexion/extension radiographs and MRI did not identify any clear evidence of nerve root contact or impingement at L4-5 or L5-S1. There was no evidence of motion segment instability, severe spondylolisthesis, or complete disc space collapse at either level that would support surgical intervention per guidelines. The stenosis was mild at L4-5 and it is not completely clear that L5-S1 is the patient's only pain generator. The patient was reported to have contributory facet effusion; however, this was not identified on radiographs or MRI. Given the lack of correlation between current physical examination findings and the provided imaging studies; and as the clinical documentation submitted for review did not contain a pre-operative psychological evaluation ruling out any confounding issues that could possibly impact post-operative recovery as recommended by guidelines, it is the opinion of this reviewer that medical necessity of the case is not established for the request is not established at this time. As the surgical request for this patient was not indicated as medically necessary there would be no requirement for a post-operative lumbar brace or requested inpatient stay. As such the prior determinations 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)