Becket Systems

An Independent Review Organization
815-A Brazos St #499
Austin, TX 78701
Phone: (512) 553-0360
Fax: (207) 470-1075
Email: manager@becketsystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/02/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: redo left L5-S1 miscrodiscectomy and new left L4-L5 hemilaminotomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Orthopedic Surgery, and Fellowship Trained Spine Surgery

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

[X] 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 <u>each</u> health care service in dispute. It is the opinion of this reviewer that the request for redo of left L5-S1 microdiscectomy and new left L4-5 hemilaminotomy is not recommended as medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his low back. The progress note dated 07/29/14 indicated the patient complaining of 8/10 low back pain. The patient demonstrated 2/3 of normal range of motion throughout the lumbar spine. No strength deficits were identified. The patient utilized Naprosyn and vicodin for pain relief. The operative note dated 06/03/14 indicated the patient undergoing left sided L5-S1 partial hemilaminectomy and medical facetectomy with microdiscectomy and foraminotomy. A clinical note dated 06/25/14 indicated the patient having difficulty lifting his left leg secondary to ongoing pain. Upon exam, give way weakness was identified throughout the left lower extremity. Decreased sensation was identified at the middle three toes of the left foot. A clinical note dated 07/17/14 indicated the patient continuing with low back complaints. The patient stated completing his activities of daily living was difficult secondary to low back pain. Generalized weakness was identified throughout the left lower extremity. The patient reported subjective loss of sensation in L5 and S1 dermatome distributions on the left. X-rays of the lumbar spine dated 07/21/14 revealed stable views of the lumbar spine with no abnormal translation on motion of between flexion/extension views.
The MRI of the lumbar spine dated 07/21/14 revealed mild very mild degenerative facet changes at L4-5. Mild ligamentous hypertrophic changes were also revealed. No canal or neural foraminal stenosis was revealed. Post-operative changes were identified at L5-S1. Large amount of scar tissue was identified. Small amount of disc material was associated with the scar. Scar tissue was partially encasing the left L5 nerve root and exiting L4 nerve root. Therapy note dated 07/30/14 indicated the patient initiating physical therapy at that time. Clinical note dated 08/15/14 indicated the patient complaining of worsening low back pain. The patient had inability to flex the hip. Paresthesia was identified at the top of the foot. Clinical note dated 08/29/14 indicated the patient initiating physical therapy. However the patient stated that it did not receive any relief of his symptoms. The patient was

recommended for L4-5 and L5-S1 procedure. Utilization review dated 08/11/14 and 08/25/14 resulted in denials as the clinical documentation revealed no completion of any post-operative conservative treatment to date. No evidence of recurrent disc herniation was identified at L5-S1 and no evidence of stenosis was identified at L4-5.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient complained of ongoing low back pain despite previous surgical intervention. Discectomy microdiscectomy and hemilaminotomy would be indicated in the lumbar spine provided that the patient meets specific criteria, including completion of all conservative treatments and imaging studies confirm significant pathology. The submitted MRI revealed no significant findings at L4-5 that would likely benefit from the proposed procedure. Additionally, no disc herniation was confirmed at L5-S1. Given these factors, the request is not indicated. As such, it is the opinion of this reviewer that the request for redo of left L5-S1 microdiscectomy and new left L4-5 hemilaminotomy is not recommended 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)

[X] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)