

Independent Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 07/06/2015

Review Outcome:

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

Neurosurgeon

Description of the service or services in dispute:

Posteral lateral interbody fusion

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)

Patient Clinical History (Summary)

The patient is a male who was originally injured on xx/xx/xx. The patient has been followed for complaints of chronic low back pain which had not improved with prior medications, physical therapy, or injections. The patient is noted to have had a prior hernia repair in 2013. MRI studies of the lumbar spine from 04/21/15 noted a small disc bulge at L5-S1 with no evidence of significant degenerative disc disease or spondylolisthesis. Radiographs of the lumbar spine also completed on 04/21/15 noted unremarkable alignment with no instability evident. The patient was initially seen on 04/16/15 with low back pain and associated lower extremity numbness, tingling, and weakness. The initial physical examination noted limited range of motion in the lumbar spine with tenderness to palpation in the lumbar paraspinal musculature. Reflexes were reported as decreased with decreased sensation in a non-specified distribution in the lower extremities. Straight leg raise testing was reported as positive bilaterally with weakness in the lower extremities again in an unspecified distribution. Updated MRI studies were recommended at this evaluation. The 05/05/15 clinical report reviewed MRI studies and recommended lumbar spinal fusion.

The requested L5-S1 lumbar spinal fusion was initially denied on 04/29/15 as the request did not meet guideline recommendations for the procedure as there was no correlation between the physical examination and imaging and no indication for lumbar spinal fusion.

The request was again denied on 06/08/15 due to lack of documentation regarding a preoperative psychological evaluation.

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

The patient has been followed for chronic complaints of low back pain radiating to the lower extremities. The patient's updated imaging from April of 2015 failed to identify any significant disc space collapse, spondylolisthesis, or any evidence of motion segment instability that would meet guideline recommendations regarding lumbar spinal fusion at L5-S1. Although the patient continued to be symptomatic despite conservative treatment, there were no clear indications for lumbar spinal fusion based on guideline recommendations. Furthermore, the clinical documentation did not include any preoperative psychological evaluation ruling out any confounding issues that could possibly impact postoperative recovery as

recommended by guidelines. As the clinical documentation submitted for review does not meet guideline recommendations for the proposed procedures, it is this reviewer's opinion that the requested services would not be considered medically necessary. As such, 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 and Environmental Medicine um
- knowledgebase AHCPR-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 Médical Literature (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)