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Notice of Independent Review Decision

Case Number:

Date of Notice: 06/20/2016

Review Outcome:

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

Orthopaedic Surgery

Description of the service or services in dispute:

L4/5 L5/S1 transforaminal lumbar interbody fusion and post spinal fusion L4 to S1 and spinal monitoring and LOS

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 reported an injury on XX/XX/XX. The mechanism of injury occurred due to XX, causing low back pain radiating to his left leg. An MRI of the lumbar spine was performed on XX/XX/XX, which noted at the L4-5 level, there was a central and right paracentral disc protrusion superimposed on a broad based disc bulge. Disc material extended up to 5 mm posteriorly. There was mild central canal and lateral recess stenosis. There was severe neural foraminal stenosis; at the L5-S1 level, there was a left paracentral and subarticular zone disc extrusion suggested. Overall, disc material extended up to 7 mm posteriorly and 15 mm inferiorly. Alternatively, a left S1 nerve root sheath lesion could have a similar configuration. There was asymmetric moderate central canal stenosis with left greater than right lateral recess stenosis. There was severe neural foraminal stenosis, left greater than right. The evaluation performed on XX/XX/XX indicated the patient had complaints of back and left leg pain. It was noted the patient was progressively getting worse and wanted to have surgery and did not want to wait for injections. It was noted that the patient has had physical therapy and was currently involved in a second session of physical therapy that was not helping. On the physical exam, the patient had positive lumbar facet pain and paraspinal spasm. Range of motion was noted to be 0 to 70 degrees flexion, 0 degrees extension, and 0 to 20 degrees right lateral bending. The patient was noted to have 3/5 strength on the left L4 anterior tibialis, extensor hallucis longus, and gastrocnemius. Reflexes were noted to be 1/3 to the L4 posterior tibialis and 0/3 to the left S1 Achilles. Sensation was decreased on the left. The patient had a positive straight leg raise on the left. The patient's treatment plan included L4/5 L5/S1 transforaminal lumbar interbody fusion and post spinal fusion L4 to S1 and spinal monitoring and LOS. According to the pre-surgical psychological assessment dated XX/XX/XX, it was noted the patient was an appropriate candidate for the proposed spinal surgery.

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

The Official Disability Guidelines state lumbar spinal fusion is only recommended as an option with spondylolisthesis, disc herniation with symptomatic radiculopathy undergoing a third decompression at the same level; revision of pseudoarthrosis; unstable fracture; dislocation; acute spinal cord injury with post-traumatic instability; spinal infections with resultant instability; scoliosis with progressive pain, cardiopulmonary, or neurologic symptoms, and structural deformity; Scheuermann's kyphosis; or tumors. The documentation submitted for review indicated the patient had MRI findings demonstrating nerve root impingement correlated with symptoms and exam findings. The patient was shown to be an appropriate candidate for the proposed spinal surgery based on the presurgical psychological assessment. The patient failed previous measures of conservative treatment with physical therapy. However, this patient was not shown to have findings of instability upon imaging or the clinical exam which is required by the guidelines. Therefore, the request is not supported. Given the above, the request for L4/5 L5/S1 transforaminal lumbar interbody fusion and post spinal fusion L4 to S1 and spinal monitoring and LOS is not medically necessary and the previous determination is 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 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 Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)