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IRO Certificate

Notice of Independent Review Decision

DATE OF REVIEW: December 14, 2012

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Anterior lumbar interbody fusion at L4-5 & L5-S1, posterior lumbar decompression with posterolateral fusion and pedicle screw. Instrumentation at L4 & L5-S1 with **assistant surgeon** and **2 day inpatient stay**. CPT: 22558, 22585, 22851, 20902, 38220 ,77002, 22612, 22614, 63047, 63048, 38220, 95937, 77002

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified: **Neurological Surgery**

DESCRIPTION OF THE REVIEW OUTCOME THAT CLEARLY STATES WHETHER OR NOT MEDICAL NECESSITY EXISTS FOR EACH OF THE HEALTH CARE SERVICES IN DISPUTE.

REVIEW OUTCOME

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

Upheld	**(Agree)**	**X**
Overturned	(Disagree)	
Partially Overturned	(Agree in part/Disagree in part)	

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Initial Preauth UR, 7/20/12
Letter of Adverse Determination, & Appeal Decision, 11/27/12, 11/13/12
Pre-Surgical Psych. Evaluation; Examiner: 8/24/12
Clinic Notes: P.A., M.D., 11/05/12, 8/13/12
Clinic Notes/Phys. Therapy Goals: Clinic:4/12/12 – 3/16/12; 2011
Medical Eval Summary, incl Supplemental Info on Patient: M.D, 11/10/11
Radiology/Labs:: 10/25/12, 3/26/12, 3/16/12
Follow Up on CT Evals/X-Rays: M.D., 5/21/12
ODG

PATIENT CLINICAL HISTORY SUMMARY

This case involves a male who sustained a work related injury in xx/xx, while cutting trees. He was attempting to 'roll' a large tree stump on the ground while standing in a forward, flexed position and felt an acute onset of lower back pain, more pronounced on the right side than the left, which radiated into the

bilateral lower extremities. Physical therapy was not helpful in dealing with his trouble. A lumbar MRI on 9/26/11showed chronic changes of the L4-5 and L5-S1 with a left L4-5 foraminal stenosis, but no changes suggesting nerve root difficulties as far as foraminal or central stenosis at L5-S1. Epidural steroid injections were denied. The patient now has pain in both lower extremities with the right greater than the left, with right foot numbness laterally, suggesting S1 nerve root trouble as was found on a 10/25/12 CT myelogram. The patient's examination revealed straight leg raising to be positive bilaterally with no reflex change, but slight weakness of dorsa-flexion on the left and Plantar weakness on the right.

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

I agree with the denial for the fusion at the L4-5 and L5-S1 levels. There is no evidence of instability on flexion or extension views or in any of the physical examination reports. The patient's acute trouble of right lower extremity pain strongly suggest disk herniation with nerve root compression on the right side. His subsequent examination and CT myelogram also indicate primary trouble at L5-S1 secondary disc rupture on the right side. There is no evidence of instability on the CT myelogram. If EMG evidence were added to the evidence suggesting left-sided L4-5 trouble, than I think exploration of that area with decompression would be indicated if, and when, surgery is done without fusion at the L5-S1 level.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)