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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
Dec/14/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Spinal Decompression and PT 3 X 4 for the lumbar, MRI of the R wrist

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Orthopedic surgeon, practicing neurosurgeon

REVIEW OUTCOME:

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

[ ] Upheld (Agree)

[ ] Overturned (Disagree)

[X] Partially Overturned (Agree in part/Disagree in part)

Overturned: MRI of right wrist
Upheld: spinal decompression and physical therapy three times four for the lumbar spine

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Physician advisor report and notice of determination 09/20/12
Physician advisor report and notice of determination 10/11/12
Pre-authorization request 09/13/12
Initial evaluation report 08/24/12
MRI lumbar spine 04/12/12
MRI pelvis 04/12/12
Notice of claim dispute 09/17/12
Pre-authorization reconsideration request 10/05/12
Letter of clarification/appeal 10/05/12

Fax cover page 09/14/12
X-rays right wrist 03/12/12
Clinical literature regarding FDA cleared lumbar decompression therapy

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who was injured when a hose reel fell on her and knocked her to the ground. She complained of pain in the right hip, tailbone, lower back, and right wrist. The claimant was seen for initial evaluation by DC. The claimant stated she had some therapy but not much help. She had medications that helped some with controlling pain. On examination, the claimant was noted to have decreased range of motion with pain in all planes of motion of the lumbar spine. She was noted to have manual muscle testing which was noted to show 4/5 weakness in the L4-5 distribution, as well as the right sacrum, right hip, right wrist, and elbow. She had a pelvic deficiency with a right short leg. Straight leg raise and Faber tests were positive on the right, increasing low back pain and right hip pain. There was spinal fascial tenderness and spasm of the paraspinal muscles of the lumbar spine and pelvis spine, as well as right hip/leg muscles, and right upper extremity muscles for wrist and forearm with palpation. There was decreased range of motion demonstrated for the right wrist and right hip with pain in all planes of motion. Deep tendon reflexes were normal, except for a decreased left patellar reflex of +1. Gait was antalgic favoring the right hip. MRI of the lumbar spine performed on 04/12/12 revealed no degenerative disc disease at L4-5 or L5-S1. At L4-5, there was diffuse disc bulge causing bilateral recess stenosis, and either of the L5 nerve roots could have been irritated. At L5-S1, there was a central disc bulge with a small annular tear. The central canal and foramen and recesses at this level were patent. X-rays of the right wrist on 03/12/12 reported bony excrescence arising from the pisiform, with possible cortical defect. The other osseous structure was unremarkable.

The request for non-surgical spinal decompression and physical therapy three times four for the lumbar spine, as well as MRI of the right wrist, was non-certified per review dated 09/20/12. It was noted that current evidence based guidelines did not support spinal decompression as there was only limited evidence available to warrant routine use of this procedure, particularly with many other well investigated and less expensive alternatives available. It was further noted that the request for 12 sessions of physical therapy was not medically necessary as the submitted clinical documentation failed to discuss prior treatment and outcomes. It was further noted that the submitted data failed to report any objective measurable clinical deficits including no clinical documentation of outcome assessments, measured range of motion, graded palpation, or other measured findings. The request for MRI of the right wrist was determined as failing to meet criteria for imaging, including acute trauma with suspicion fracture and normal radiographs. Additional criteria included suspicion of gatekeeper injury, chronic pain with suspicion of tumor, chronic pain with suspicion of osteo ischemic necrosis disease, and normal plain films.

A reconsideration request for spinal decompression and physical therapy three times four for the lumbar, and MRI of the right wrist was non-certified and the original non-certification determination was upheld per review dated 10/11/11. The reviewer noted that the requesting doctor stated that the claimant had never had any physical therapy or therapy on the right wrist. X-rays on the right wrist were the only diagnostic studies performed to date on the right wrist. Decompression therapy was not supported by evidence based guidelines. The claimant did not meet Official Disability Guidelines criteria for MRI on the upper extremity at this time. It was noted that the claimant had never completed and failed a course of conservative therapy or physical therapy prior to requesting an MRI on the upper extremity. There was no evidence of progress with objective functional improvement with prior physical therapy. It was noted that the claimant had already had sufficient supervised therapy to continue with home exercise program. It was noted that there were no red flags or compelling rationale that would substantiate medical necessity of additional supervised therapy over a self-directed home exercise program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND

CONCLUSIONS USED TO SUPPORT THE DECISION:
Based on the clinical information provided, the request for spinal decompression is not supported as medically necessary. The claimant reportedly was injured on 03/06/12. She has multiple complaints including pain in the right hip, tailbone, low back, and right wrist. MRI of the lumbar spine revealed disc desiccation at L4-5 and L5-S1 with quite severe disc space loss at L4-5 with minimal disc space loss at L5-S1. A diffuse disc bulge was noted at L4-5 causing bilateral recess stenosis. The radiologist noted that either of the L5 nerve roots could be irritated at this level. At L5-S1, there is a central disc bulge, but no central canal or foraminal narrowing. There is no clinical documentation that the claimant has had previous conservative care for the low back, including physical therapy, activity modification, bracing, epidural steroid injection, or other conservative measures. Current evidence based guidelines do not support the use of vertebral axial decompression, intervertebral disc decompression, or powered traction devices as there is no strong scientific evidence showing this treatment to be effective. As such, the request for spinal decompression is not recommended as medically necessary. The request for physical therapy three times four for the lumbar spine is not supported as medically necessary given the clinical data presented. There is no comprehensive history of the nature and extent of treatment to date for the lumbar spine, including previous physical therapy or other conservative measures.

The request for MRI of the right wrist is recommended as medically necessary. The claimant complains of ongoing right wrist pain. Records indicate that the claimant has had a brief course of physical therapy for the right wrist without significant improvement. X-rays of the right wrist on 03/12/12 revealed bony excrescence arising from the piriformis with possible cortical defect between the excrescence and the pisiform. MRI of the right wrist is warranted to further delineate possible soft tissue pathology not visualized on plain radiographs, and to determine appropriate treatment for the right wrist.

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)

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