

SENT VIA EMAIL OR FAX ON
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Applied Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/29/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient lumbar surgery to include examination under anesthesia, lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, and implantation of bone growth stimulator (EBI) at L5/S1

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

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

This xx year old female smoker sustained an injury to her low back on xx/xx/xx when she trip over wires on floor, stumbled, twisted and almost fell. The claimant was initially diagnosed with lumbar sprain/strain, muscle spasm and rule out lumbar disc injury and was treated conservatively with medications, physical therapy and off work.

A lumbar MRI was performed on 09/11/08 and revealed a mild posterior central disc protrusion at L5-S1. The claimant underwent lumbar epidural steroid injections with post injection physical therapy which was noted to have been of benefit but only temporarily.

The claimant was evaluated by Dr. on 10/21/08 and underwent lumbar spine x-rays which included flexion and extension views and showed the L5-S1 extension angle to measure 30 degrees with facet subluxation, foraminal stenosis and lateral recess stenosis and the extension angle at L4-5 was 20 degrees. Objective exam findings included a positive spring test at L4-5 and L5-S1, positive sciatic notch tenderness on the left and positive Fortin finger test on the left. Additional findings include a positive flip test bilaterally; a positive straight leg raise on the left at 45 degrees and a contralateral positive straight leg raise on the right at 75 degrees with pain referred in her back and left lower extremity. Left knee and ankle jerks were decreased, the posterior tibial tendon jerk was absent bilaterally, and she had paresthesias in L5 and S1 nerve root distribution on the left, and weakness of gastroc soleus on left with a

positive extensor lag.

A second opinion performed by Dr. on 10/22/08 documented findings of a lumbar disc injury L5-S1 and mild spasms and recommended the claimant proceed with additional epidural steroid injections but noted that Dr. would be best to determine if the claimant was a surgical candidate.

An EMG/NCV study performed on 10/30/08 revealed evidence of acute/ongoing bilateral L5 radiculopathy. A presurgical mental health evaluation performed on 11/17/08 revealed an adjustment disorder with mixed anxiety and depressed mood and moderate psychosocial stressors related to her injury and recommended 6 individual psychotherapy sessions but noted the claimant had a good prognosis for the proposed surgical procedure. A functional capacity evaluation performed on 12/08/08 listed the claimant at a current sedentary job level. Dr. documented the claimant must stop smoking for a least 6 weeks and recommended a decompressive lumbar laminectomy, discectomy, arthrodesis with internal fixation and a bone growth stimulator unit following failed conservative care which included physical therapy, medications, activity modifications and lumbar epidural steroid injections.

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

The requested lumbar L5-S1 laminectomy, discectomy, fusion, instrumentation, and bone growth stimulation is not medically necessary based on review of this medical record.

This record indicates this person was injured a little more than four months ago with a twisting event and since that time has had ongoing back and bilateral leg complaints. She has been treated with therapy, medications, and injections without change in her complaints.

She has undergone an MRI, which indicates a mild posterior central disc protrusion L5-S1, but it does not describe a disc herniation or nerve root impingement. She has an EMG documenting bilateral L5 and S1 radicular changes, as well as what Dr., in a 10/21/08 note, seems to indicate L4-5 instability on flexion/extension stress lateral x-rays.

ODG guidelines document the use lumbar decompression in patients who have a proven disc herniation with neurologic deficit and evidence that the disc herniation is causing pressure on the nerve root, as well as failure of conservative care to include medications, injections, and therapy. Fusion is used in patients who had all the pain generators identified, failure of conservative care, evidence of structural instability, and a psychosocial screen with confounding issues addressed.

In this case, she has had a psychosocial screen, which would seem to indicate a good prognosis for surgical procedure, although they did wish to treat her from a psychological point of view. It is also unclear as to why an L5-S1 operative procedure is being requested since the structural instability has been described at the L4-5 level, and the EMG changes were at multiple levels.

Therefore, since all of this does not seem to fit together in a clear history such as why there is documentation in the record of an L4-5 instability, yet L5-S1 is the level being requested for surgery, and the fact that the claimant is still receiving psychologic care, which might indicate a decreased rate of improvement following surgery, then the requested surgical intervention is not medically necessary.

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

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

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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