

Applied Assessments LLC

An Independent Review Organization
1124 N. Fielder Road, #179, Arlington, TX 76012
(512) 772-1863 (phone)
(512) 857-1245 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: 05/20/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Spinal surgery (LOS).

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

M.D., 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)

Upon independent review the reviewer finds that the requested spinal surgery (LOS) is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is an injured worker whose problems began sometime ago, date of injury xx/xx/xx. The patient initially had a work-related injury while moving racks of clothes. Apparently she fell and had right groin pain as well as back pain. She had some conservative care including epidural steroid injections with no relief. She underwent surgery at the L4/L5 and possibly L5/S1 levels. In December 1994 she had low back pain with radiating pain to the right lower extremity in the L5 distribution. She apparently also had positive straight leg raising of the right lower extremity. Dr. began to look after her in December 1994 until May 2007. Under Dr.'s care she has undergone the injection in April 1994, a right L4/L5 discectomy in August 1994, an L4/L5 decompressive laminectomy with instrumentation of posterolateral fusion in May 1996, L4 to S1 exploration with fusion removal of hardware in September 1997, and revision of fusion of L5/S1 with an L5/S1 pseudoarthrosis noted, exploration of the pseudoarthrosis at L4/L5 and L5/S1 in May 1999, revision in association with carbon fiber cages at L4/L5 and L5/S1, re-exploration

for lumbar fusion at L4/L5 and L5/S1, and decompression of the right S1 nerve root and bone graft in June 2004. Dr. has continued to see the patient and notes continuing pain and lower extremity weakness. He believes there is a pseudoarthrosis at L4/L5 and L5/S1 and recommends further surgery. There has been note of a spondylolisthesis at L3/L4. In February 2007 CT scan suggested pseudoarthrosis particularly at L5/S1, and Dr. recommended re-fusion. Repeat diagnostic studies in 2007 were normal. The patient has had psychological evaluations indicating that there may well be a psychological component to the condition with chronic pain syndrome. Discussion of possible psychological counseling prior to spinal cord stimulator has been raised. The patient currently takes Duragesic, Talwin, Skelaxin, Neurontin, Zanaflex, and Flexeril.

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

Upon review of the provided medical records and ODG Guidelines this reviewer finds that the requested spinal surgery (LOS) is not medically necessary. This reviewer feels that after the number of surgeries the patient has undergone, the statistical chance of obtaining a fusion is minimum at best, particularly when a posterior approach is being recommended. ODG Guidelines do recognize the benefits of lumbar fusion up to two levels. However, in this particular situation, this has already been accomplished, and one wonders what the optimism for potential successful pseudoarthrosis repair at this time is due to. It is for this reason, i.e. the multiple failed attempts to obtain a fusion and the clinical condition of the patient in conjunction with the ODG Treatment and Disability Guidelines and the peer-reviewed literature, which would not support optimism for fusion given the number of previous attempts at fusion. The previous adverse determination is upheld.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE
- AHCP- 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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)