



Notice of Independent Review Decision

DATE OF REVIEW: 10/7/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique).

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

Texas licensed 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique).

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice to utilization Review Agent of Assignment of Independent Review Organization Sheet dated 9/30/08.
- Fax Cover Sheet dated 9/30/08.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 9/30/08.

- Notice to . of Case Assignment sheet dated 9/30/08.
- Request for a Review by an Independent Review Organization Sheet dated 9/29/08.
- Follow-Up Note dated 9/22/08, 6/30/08, 6/27/08.
- Treatment/Service Request Note/Letter dated 8/15/08, 7/25/08.
- Summary of Treatment/Case History dated 8/15/08, 7/25/08.
- Pre-Authorization for Workers Comp Sheet dated 8/12/08.
- Texas Workers' Compensation Work Status Report dated 8/5/08, 7/21/08, 5/12/08.
- SOAP Note dated 8/5/08, 6/10/08, 5/13/08, 4/22/08, 3/27/08, 3/26/08, 3/25/08, 3/6/08.
- Chronic Pain Evaluation dated 7/31/08.
- Summary of Medical Records/Letter dated 7/23/08.
- Preauthorization for Workers Comp Sheet dated 7/22/08.
- Prescription dated 7/21/08.
- Return Patient Visit Note dated 7/21/08, 5/12/08.
- Doctor's Note/Letter dated 7/21/08.
- Recent History of chief Complaint Summary dated 7/21/08.
- Clinic Note dated 4/15/08, 3/27/08.
- History of Present Illness Summary dated 2/25/08.
- Electrodiagnostic Results dated 1/14/08.
- Magnetic Resonance imaging of the Lumbar Spine/Letter dated 12/21/07.
- Diagnostic Imaging Consultation dated 12/11/07.
- Authorization Letter (unspecified date).

No guidelines were provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Hit by a forklift in the back, pinning him between a truck bed.

Diagnosis: Avascular necrosis of the left hip; Lumbar disk syndrome; Lumbar radiculitis; Thoracic pain; Pelvic pain.

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

The claimant is a xx-year-old male with the date of injury . Mechanism of the injury, the claimant was hit on the back and left hip by a forklift. The diagnoses included:

1. Avascular necrosis of the left hip.
2. Lumbar disk syndrome.

3. Lumbar radiculitis.
4. Thoracic pain.
5. Pelvic pain.

Post injury, the claimant was seen in the emergency room in [redacted] and subsequently began care in [redacted] DC, with complaints of low back pain and pain radiating to both legs. The MRI of December 21, 2007, noted avascular necrosis (AVN) and osteoarthritis of the left hip and lumbar spine with broad-based disk protrusion at left posterior with no evidence of nerve root compression L4-L5 and L5-S1. An electrodiagnostic study dated January 14, 2008, noted changes suggestive of radiculopathy at L4-L5 on the left in the paravertebral muscle mass and suggesting changes at L5 or S1. The claimant was subsequently seen by [redacted], MD, who performed epidural steroid injections that were of no significant benefit. The claimant continued to see Dr. [redacted] for chiropractic treatment and on May 12, 2008, Dr. [redacted] recommended consideration of the left total hip replacement and surgical treatment of the back. A lumbar myelogram CT on June 27, 2008, noted extradural defects between T11-T12, T10-T11, with loss of height at the T11 body, with displacement into the spinal canal with secondary impingement on the conus. Also a 1 to 2 mm diffuse protrusion at L5-S1 was noted that minimally deformed the ventral dura and resolved reflection. Calcification of the ligamentum flavum with hypertrophy T11 was noted. The claimant has been seen multiple times by Dr. [redacted] and Dr. [redacted]. The claimant did have a medical record reviewed by [redacted], M.D. on July 23, 2008, who opined that there was lack of adequate evidence to support the requested lumbar fusion as the medical records did not demonstrate clear, convincing evidence of radiculopathy as there was no evidence of weakness, reflex loss, or areas of paresthesias in a dermatomal pattern. He noted that the request for fusion for low back pain was very controversial and applying ODG, he did not feel supported the surgical request. In a rebuttal letter, Dr. [redacted] took issue with that report and he noted on his physical examination hypomobile left Achilles reflex. The first time that was noted that I can see in the medical records was hypesthesia corresponding to L4, L5, and S1 on the left. Again, the first time in the medical records it was noted was by a designated doctor evaluation July 31, 2008, by Dr. [redacted]. The fax report could not be deciphered. The prior peer reviews noted recommendation for denial of the request as there had not been identification of all pain generators and the claimant had not undergone a psychological evaluation. It did note that the claimant underwent chronic pain evaluation but did not include testing and Dr. [redacted] did not feel that constituted an appropriate psychological evaluation. Also minimal non-operative treatment, other than the epidurals and some physical therapy had been performed and he felt the claimant certainly required exhaustive screening and non-operative treatment prior to consideration of surgery for this condition. This reviewer is in agreement in with Dr. [redacted] and with Dr. [redacted]. It appears that the first time, there has been a notation of any neurological findings was the response by the Dr. [redacted] and to the review by Dr. [redacted]. One would assume that those findings should have been previously mentioned. Dr. [redacted] had noted the neurological findings, but Dr. [redacted] in his request and in his medical records did not find hypesthesia in the dermatomal pattern and did not note hyporeflexia in his medical records. Therefore, at this time, this reviewer would support the recommendation of the prior peer reviewer. The surgical procedure is not indicated, and this is in line with the Official Disability Guidelines, web-based 13th edition and one should first

weigh and note the designated doctor's evaluation that was performed on July 31, 2008. That report was not made available to this reviewer. Therefore, at this time, this reviewer acknowledges that it would be better for this claimant's care to note the designated doctor's evaluation and findings and then proceed with further investigation into the pain generators.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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 AND 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).