

SENT VIA EMAIL OR FAX ON
Apr/13/2009

Applied Assessments LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/13/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient lumbar surgery, lumbar laminectomy, discectomy at L4/5 and L5/S1; arthrodesis with cages, posterior instrumentation at L5/S1

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female smoker with a date of injury xx-xx-xx, when she fell out of a bus while exiting. She complains of low back pain and bilateral lower extremity pain, left worse than right. It is noted on 09/6/2008 that she is recommended to undergo PT: 4 units of therapeutic exercises, 1 unit myofascial release, 1 unit of interferential stimulation, and 1 unit of ultrasound. It is unknown whether this therapy was ever completed. She has declined epidural steroid injections. An EMG 10/22/2008 revealed no involvement of the motor nerve

roots by needle examination but here was some delay of the bilateral peroneal and tibial F wave and tibial R reflexes which may indicate a low grade chronic radiculopathy, despite a lack of acute changes. The neurological examination revealed a decreased knee and ankle jerk on the left, absent posterior tibial tendon jerk bilaterally, paresthesias in the left L5 and S1 nerve distribution, and weakness of the left gastrocnemius and extensor hallucis longus. MRI of the lumbar spine 08/08/2008 reveals a mild spondylotic disc bulge with mild asymmetric left disc bulge at L4-L5. At L5-S1 there is a posterior central disc bulge. The provider believed the flexion and extension films of the lumbar spine to reveal an abnormal extension angle at L5-S1 at 19 degrees with facet subluxation. At L4-L5 there was an extension angle borderline at 11 degrees with facet subluxation. Other than his interpretation, the radiological report of these films is not provided. Psychological clearance has been given.

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

The procedure is not medically necessary. Firstly, it is unclear, from the submitted documentation, that an adequate course of conservative measures has been undertaken. A few sessions of PT is recommended, and it is known that the claimant has refused an epidural steroid injection. However, it is not known, based on the submitted documentation, how much conservative therapy has been undertaken. Secondly, it is not clear that there is significant pathology warranting decompression at L4-L5. By examination, there are neurological findings in the left leg. However, the radiology report does not report any significant nerve root compression or displacement. Secondly, any imaging reports detailing the instability at L5-S1 are not included for review. It is not apparent, therefore, that L5-S1 needs to be fused. Therefore, based on the reasons above, the surgery is not medically necessary.

References/Guidelines

ODG "Low Back" chapter

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)