

SENT VIA EMAIL OR FAX ON
Jul/26/2009

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

2 day LOS lumbar surgery to include exam under anesthesia, lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation and implantation of bone growth stimulator @L4/5-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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

MRI lumbar spine 05/05/08

EMG 05/05/08

X-rays 12/05/08

Office notes 03/20/09, 04/03/09

Behavioral Health note 04/03/09

Office notes Dr. 04/07/09, 04/06/09

review 06/12/09

review 06/29/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx-year-old male injured on xx/xx/xx. He has had low back pain and at

least some degree of bilateral leg pain.

A 05/05/08 MRI lumbar spine showed an L3-4 disc bulge with left neural narrowing. There was disc narrowing at L4-5 with a posterior protrusion, left disc bulge and left neural canal narrowing. At L5-S1 there was a posterior disc protrusion with left neural narrowing and bilateral facet degenerative changes. The 05/05/08 EMG showed moderate L3-4 radiculopathy, L5-S1 bilateral radiculopathy

A 04/03/09 Behavioral Health evaluation opined that the claimant was well prepared to undergo surgery.

On 04/07/09, Dr. noted the claimant had back and bilateral leg pain. He noted the claimant had been treated with an exercise program, medications, epidural steroid injection. X-rays per Dr. showed L4-5 bone on bone spondylosis and stenosis with lateral recess stenosis, anterior osteophytes and 5 millimeters of retrolisthesis in extension. At L5-S1 there was bone on bone spondylosis with lateral stenosis, osteophytes and 4mm retrolisthesis in extension. MRI done yesterday shows disc pathology with contained herniation at L4-5 and L5-S1. On examination there was a positive spring, Lasegue's, flip, Bragard's and sciatic nerve testing. He had decreased knee jerk and ankle jerk on the left and absent tibial tendon jerks bilaterally. There was paresthesia in L5 and S1 on the left. He had weakness of the extensor hallucis longus, gastrocnemius and tibialis anterior on the left.

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

Multilevel spine fusion surgery from L4 to S1 and two-day length of stay is not medically indicated and appropriate. This is a xx-year-old male who was injured on xx/xx/xx. The records reflect that there are abnormal neurologic findings consistent with radiculopathy. An MRI on 05/05/08 demonstrates L3-4 disc bulge L4-5 protrusion and disc bulge, and L5-S1 protrusion and left neural foraminal narrowing and bilateral facet degenerative change. On the same day an EMG demonstrated moderate L3-4 radiculopathy, L5-S1 bilateral radiculopathy. Radiographs do not demonstrate any instability. However, there has been evidence of a fixed spondylolisthesis in the lower segment. On 04/03/09 he demonstrated feasibility for undergoing surgery to rule out confounding factors. However, there has been documentation of compliance and consistent treatment over a six-month period of time, which is necessary to undergo fusion with these clinical parameters, as there is no tumor, infection, or obvious instability. Based on the documentation surgery is not indicated and appropriate and consistent with ODG guidelines.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates

Patient Selection Criteria for Lumbar Spinal Fusion

For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include: (1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical disectomy. [For excessive motion criteria, see AMA Guides, 5th Edition, page 384 (relative angular motion greater than 20 degrees). (Andersson, 2000) (Luers, 2007)] (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. [For spinal instability criteria, see AMA Guides, 5th Edition, page 379 (lumbar inter-segmental movement of more than 4.5 mm). (Andersson,

2000)] (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria

Milliman Care Guidelines
Inpatient and Surgical Car
13th Edition

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)