

SENT VIA EMAIL OR FAX ON
Nov/10/2009

Applied Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/10/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

posterior lumbar laminectomy and fusion L5/S1 right instrumentation L5/S1, caging L5/S1, local autograft; Tranforaminal epidural steroid injection; assistant surgeon

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 right hip 11/05/08

Office notes Dr. 12/19/08, 01/14/09, 01/30/09, 03/25/09, 04/30/09, 05/15/09, 06/15/09, 06/30/09

MRI lumbar spine 01/23/09

Office notes Dr. 02/12/09, 03/09/09, 03/20/09, 05/28/09, 08/12/09, 09/14/09, 10/19/09

Operative report Dr. 04/24/09

FCE 07/07/09

Office note Dr. 08/11/09

Peer review Dr. 08/26/09

Office note PA 09/10/09

Office note Dr. 09/30/09

Peer review 10/14/09

FCE 12/16/08

PATIENT CLINICAL HISTORY SUMMARY

This is a female with complaints of low back pain and right lower extremity pain associated with weakness, numbness and sometimes gives way. The MRI of the right hip showed right hip-reactive changes within the greater trochanter of the femur and fluid within the adjacent bursa in keeping with trochanteric bursitis. There was no evidence for fracture or avascular necrosis. There was osteoarthritis of both hips and irregularity of the anterior superior margin of the acetabulum with subacromial cysts and reactive changes likely degenerative in nature. The MRI of the lumbar spine from 01/23/09 showed at L5-S1 a prominent generalized riding and associated bulge and moderate facet arthropathy which resulted in significant bilateral foraminal compromise with definite potential for impingement upon the exiting nerve roots bilaterally. There was a bulge, spur and associated facet arthropathy L1-2 through L4-5. The 03/09/09 and 04/24/09 lumbar epidural steroid injections provided 2 days of relief. The 08/11/09 lumbar spine x-rays showed a collapsed disc at L5-S1 causing foraminal stenosis and then vacuum phenomenon at L5-S1. The 09/10/09 lumbar spine x-rays showed L5-S1 collapsed disc vacuum phenomenon and significant lumbar spondylosis. Flexion and extension films of the lumbar spine showed significant decreased disc space at L5-S1 with opening up at the posterior aspect of disc space while in flexion, but no significant translation or signs of instability observed. On 09/30/09, the psychologist deemed the claimant as an appropriate for surgery. The most recent examination on 10/19/09 revealed strength of 5-/5 with knee extension and hip flexion especially on the right. The diagnoses included lumbar radiculopathy, neural foraminal impingement at L5-S1 and low back pain. The claimant has been treated with physical therapy, Vicodin and Skelaxin.

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

The requested L5-S1 laminectomy and fusion cannot be justified as medically necessary according to a careful review of all medical records.

It is unclear why the treating surgeon has requested a fusion for this claimant. Fusion in the absence of instability or fracture is generally not recommended. In this case, the claimant specifically is noted to have no significant translation or signs of instability. The rationale for the fusion is unclear and cannot be justified as medically necessary according to the information reviewed.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, chapter low back, fusion and epidural steroid injection

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see [discography criteria](#)) & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) [Psychosocial screen](#) with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. ([Colorado, 2001](#)) ([BlueCross BlueShield](#)).

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)