

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/06/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

4 day inpatient stay and L4-S1 Spinal Surgery

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

Office Record, 06/16/09

Office notes, , PA-C, 06/22/09, 07/13/09

Office notes, Dr. , 07/22/09, 07/29/09, 08/05/09, 08/26/09

Office notes, Dr. , 07/30/09, 08/20/09

Peer review, Dr. , 08/14/09

Peer review, Dr. , 08/24/09

PATIENT CLINICAL HISTORY SUMMARY

This xx-year-old male sustained an injury to his low back on xx/xx/xx when he fell forward landing on his side. Documentation revealed a prior history of lumbar decompression at an unknown level approximately 20 years ago with an L4-5 decompression performed on 05/02/06. The claimant was reported to have done well and returned to full duty status with only mild chronic low back pain until the date of his recent injury. The lumbar MRI dated 07/16/06 revealed significant change from the prior MRI with new or progressive large L4-5 right paracentral protrusion impinging upon the right lateral recess and specifically the right L5 nerve root that resulted in mild overall central stenosis. There were significant L5-S1 changes with the prior small right paracentral protrusion now moderate in size causing moderate impingement upon the right S1 nerve root.

A surgical evaluation completed on 07/30/09 revealed subjective complaints of continued severe and incapacitating back, buttock and right leg pain unresponsive to conservative management that included multiple oral medications and pain injections, chiropractic care, physical therapy and activity modifications. The exam revealed a significant gait disturbance, muscle spasms, restricted range of motion, tenderness, weakness and decreased reflexes. Dr. requested authorization to proceed with an L4-5 decompression, posterior spinal fusion, pedicle screw fixation and iliac crest bone graft.

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

The requested surgery cannot be justified as medically necessary at this time based on the information provided.

The extent of prior conservative care is unknown. Records do not clearly reflect that the claimant has received physical therapy for his current condition. In addition, the treating surgeon has requested a two-level fusion for the claimant in the absence of documented instability.

Though the claimant may require a revision decompressive procedure if he has truly failed conservative measures, it is not clear why a fusion has been requested. Further information would be required to justify the surgical request for a two-level fusion for this claimant.

In addition, the request for a four-day stay exceeds the typical Milliman guidelines that allow up to a three-day stay.

Milliman Care Guidelines® Inpatient and Surgical Care 13th Edition

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates: Low Back – Spinal Fusion

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)