

SENT VIA EMAIL OR FAX ON
Apr/02/2010

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/02/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Laminectomy / Discectomy Lumbar L5/S1 with inpatient stay

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

OD Guidelines

Denial Letters 3/4/10 and 3/10/10

Neck and Back 11/20/09 thru 1/4/10

MRI 10/21/09

Ortho 11/10/09 thru 2/25/10

PATIENT CLINICAL HISTORY SUMMARY

This is a female with a date of injury xx/xx/xx, when she tripped and fell forward. She complains of low back pain radiating to the left lower extremity. She has undergone physical therapy and ESIs. Her neurological examination is normal. An MRI of the lumbar spine on 10/21/2009 showed a central disc herniation at L5-S1, possible spina bifida occulta at L5-S1 and a small fat signal mass adjacent to the inferior aspect of the L5 spinous process to the right of midline suggestive of a lipoma. There is no central stenosis and the neuroforamina are patent. The provider is requesting an L5-S1 discectomy with inpatient stay.

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

The surgery is not medically necessary. The claimant has no objective evidence of an S1 radiculopathy. Moreover, her neuroimaging does not demonstrate any nerve root compression. According to the ODG, "Low Back" chapter, there should be imaging studies

“requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings: A. Nerve root compression (L3, L4, L5, or S1) B. Lateral disc rupture C. Lateral recess stenosis”. This is not present on her imaging studies. It is not clear that a discectomy at L5-S1 would alleviate her symptoms. The procedure is, therefore, not medically necessary.

References/Guidelines

2010 *Official Disability Guidelines*, 15th edition
“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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)