

SENT VIA EMAIL OR FAX ON
Dec/06/2010

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/06/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar laminectomy with fusion L3/4 and a one day 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 10/28/10, 10/13/10, and 11/5/10; Dr. 3/31/08 thru 10/18/10; OP Report 9/29/10, Radiology Reports 9/29/10 and 3/10/08; Dr. 10/22/10; Physician Advisor Reports No Date

PATIENT CLINICAL HISTORY SUMMARY

This is a female with a date of injury xx/xx/xx, when she slipped and fell on soapy water on the floor. She is status post L4-L5 and L5-S1 fusions (4 prior lumbar surgeries, with the last being in 2007). She has undergone extensive pain management. She complains of severe low back pain with bilateral radiating leg pain. The provider states on 10/18/2010 that she has left quadriceps weakness. A myelogram/CT 09/29/2010 shows a markedly decreased canal dimension of 7.5 millimeters due to disc bulge and facet and ligament hypertrophy. The provider is requesting a lumbar laminectomy with fusion at L3-L4 with a one-day inpatient stay.

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

The proposed surgery is medically necessary. The claimant has adjacent level degeneration and stenosis. She has weakness associated with this. The treatment for this is a

decompression and extension of fusion. According to the ODG, “Low Back” chapter, a lumbar fusion is indicated for “revision surgery for failed previous operation(s) if significant functional gains are anticipated”. Given the degree of stenosis and debilitating leg pain, it is likely that the surgery will greatly improve her symptoms. There are functional gains anticipated from the proposed procedure. It is, therefore, medically necessary. A one-day hospitalization is reasonable for this procedure

References/Guidelines

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

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