

SENT VIA EMAIL OR FAX ON  
Jun/10/2010

## Applied Assessments LLC

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jun/10/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Posterolateral Lumbar Interbody Fusion @L4/5, L5/S1; Fusion Extra Segment; Insertion of Spinal Cage with Bone Marrow Aspiration and Synthetic Bone Graft; Lumbar Spine with Posterior Instrumentation @ L4/5, L5/S1, Fusion Extra Segment; Application of Spinal Prosthetic Device @ L4/5, L5/S1; Revision Decompression with Laminectomy, Single Lumbar; Addition Level; Inpatient Hospitalization 3 days

**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 4/1/10 and 4/22/10

IRO Summary 5/28/10

Bone & Joint 12/7/09 thru 3/9/10, OP Report 2/22/10

Associates 10/3/07 thru 3/3/09

Lumbar Myelogram 10/22/08

Hospital Note 9/27/07

MRIs 10/10/07, 11/6/07, 1/11/10

CT Lumbar Spine 10/26/07

OP Report 11/8/07

122 pages from Carrier 9/27/07 thru 5/28/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male with a date of injury xx/xx/xxxx when he was moving heavy boxes. He complains of low back and bilateral leg pain. He underwent a lumbar discectomy on

11/08/2007 and revision discectomy on 11/25/2008 at L4-L5 and L5-S1 on the left. Apparently, prior to all this, he has undergone an L5-S1 discectomy in the past. He has undergone ESIs. On examination, there is weakness in the left EHL. Reflexes are absent in the ankles bilaterally. An MRI of the lumbar spine 01/11/2010 reveals at L4-L5 bilateral 3mm protrusions with left greater than right facet arthropathy, creating mild stenosis with left greater than right lateral recess and foraminal encroachment. At L5-S1 there is a central-to-right 6mm herniated disc. There is moderate stenosis with right greater than left lateral recess, foraminal and S1 nerve root encroachment. The provider is recommending a posterolateral Lumbar Interbody Fusion @L4/5, L5/S1; Fusion Extra Segment; Insertion of Spinal Cage with Bone Marrow Aspiration and Synthetic Bone Graft; Lumbar Spine with Posterior Instrumentation @ L4/5, L5/S1, Fusion Extra Segment; Application of Spinal Prosthetic Device @ L4/5, L5/S1; Revision Decompression with Laminectomy, Single Lumbar; Addition Level; Inpatient Hospitalization 3 days

**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 at least a third time recurrence of disc herniation/protrusions at L4-L5 and L5-S1. He has radicular signs and symptoms with weakness in his left foot. The standard treatment would be a lumbar decompression and fusion at the involved levels, and this is reflected in ODG criteria for a lumbar fusion. Given that he needs to be decompressed for the radiculopathy, a fusion would be done simultaneously to prevent further disc herniations. A psychosocial evaluation is not needed in this circumstance.

*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)