

SENT VIA EMAIL OR FAX ON
Jul/06/2010

Applied Assessments LLC

An Independent Review Organization

1124 N Fielder Rd, #179

Arlington, TX 76012

Phone: (512) 772-1863

Fax: (512) 857-1245

Email: manager@applied-assessments.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/06/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient 360 diffusion @ L5-S1, LOS 3-4 days

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 notes, Dr08/15/07, 09/27/07, 12/27/07, 05/13/08, 09/30/08, 02/04/09, 05/13/09, 07/29/09, 09/14/09, 12/28/09, 01/20/10, 03/17/10, 04/07/10, 04/14/10

Office notes, , 08/23/07, 01/22/08, 02/27/08, 02/17/09, 11/11/09, 04/27/10, 05/12/10

MRI Thoracic Spine, 05/01/09

MRI Lumbar Spine, 05/01/09

Lumbar Discogram, 04/05/10

Mental Health Assessment, 05/06/10

Peer review, Dr., 05/19/10

Peer review, Dr., 06/08/10

Post Procedure Progress Note and History/Physical – Physician Unknown; Imaging Pictures x5: 04/05/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male claimant with a reported low back injury that occurred while at work on xx/xx/xx. The diagnosis is L5-S1 herniated nucleus pulposus and lumbar degenerative disc disease. On 08/15/07, Dr. documented findings from the 09/20/06 thoracic MRI that revealed T 6-7, T 7-8 and T8-9 disc bulges along with lumbar MRI findings that revealed a central disc protrusion adjoining the ventral aspect and thecal sac encroaching upon the neuroforamen bilaterally. He also documented findings from an EMG/NC study done on 10/11/06 that revealed lumbar radiculopathy. Conservative treatment was ordered and he was placed at maximum medical improvement on 09/27/07.

Provided records revealed the claimant continued conservative treatment throughout 2008 into early 2009 when he reported worsening symptoms. On 05/01/09, the claimant underwent a thoracic MRI that revealed degenerative process of mild to moderate degree throughout the spine. The lumbar MRI also performed on 05/01/09 demonstrated degenerative disease throughout with a focal central protrusion at L5-S1 level that extended from the midline toward the right consistent with either osteophytes or disc herniation, protruding into the canal causing mild to moderate spinal stenosis. On 07/29/09, Dr. noted the claimant did have an L5-S1 disc herniation and mid thoracic disc herniation with no surgical pathology treated conservatively.

A lumbar discogram was performed on 04/05/10 at L3-4, L4-5, and L5-S1 with positive concordant pain production and architectural changes at L5-S1. On 04/07/10, Dr. noted the claimant clearly had L5 on S1 retrolisthesis with mainly low back pain and pseudoradicular bilateral lower extremity symptoms, which had failed to improve with exhaustive conservative measures. Records noted conservative care over the years included the passage of time, physical therapy and medications with a notation the requested epidural steroid injections were denied by the carrier. A mental health assessment completed on 05/06/10 cleared the claimant for the proposed surgical procedure. Dr. requested authorization to proceed with a 360 degree L5-S1 fusion with a 3 to 4 day inpatient length of stay.

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

The request is for an L5-S1 fusion, 360 degrees. The claimant has had chronic pain. He does have a positive discogram and has had rather extensive conservative treatment. It is felt that he has discogenic pain. The claimant had a mental health assessment on 05/06/10. It was felt that he would be a candidate for surgery.

In light of his positive discogram with concordant pain and failure to respond to conservative treatment, surgery would be medically necessary. The claimant has undergone a previous psychosocial assessment. There are no psychological reasons contraindicating the requirement for fusion.

Pain generators have been identified, that being a positive discogram. He has failed conservative treatment. He had psychosocial screening. In light of such, surgery would be medically necessary with a three-day length of stay.

The claimant appears to have primarily mechanical back pain due to functional spinal unit failure. The claimant does appear to be a candidate based on ODG guidelines.

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)