SENT VIA EMAIL OR FAX ON
May/15/2010

Applied Assessments LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
May/15/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Inpatient RE-DO L5/S1 Lami/Discectomy Lat fusion with instrumentation

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:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 2/24/10 and 3/12/10
Dr. 4/1/09 thru 4/21/10
xxxx 12/21/09
MRIs 10/15/09 and 3/23/09
Lab Results 8/5/09
OP Report 8/4/09
xxxxx 3/2509 thru 6/23/09
Management 5/19/09 thru 6/26/09

PATIENT CLINICAL HISTORY SUMMARY
This is a female, with a date of injury, when she was lifting some heavy bags of laundry. She underwent an L5-S1 discectomy on 08/04/2009. She did well for the first month, but then began to have increasing pain in her legs, as well as her back. She is on pain medications

and NSAIDs. She has tried oral steroids, muscle relaxants, and pain medications. Her examination reveals some weakness in the plantar flexors, particularly on the right. An MRI of the lumbar spine 10/15/2009 reveals a central disc herniation with no significant mass effect upon the traversing nerve roots and neuroforamina. The provider is requesting an L5- S1 redo laminectomy/discectomy with fusion and instrumentation. A second opinion with Dr. Michael Leonard 12/21/2009 concurred that a decompression and fusion were warranted. The provider is requesting a 360-degree surgery at L4-S1 with a 4-day length of stay. He believes that due to the significant disc space collapse and mechanical back pain, that a lumbar fusion should be done, as well as a re-do decompression. He stated on 03/22/2010 that there are no psychosocial issues involved.

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

The proposed surgery is not medically necessary. According to the ODG, “Low Back” chapter, “all physical medicine and manual therapy interventions” should be completed. It does not appear that the claimant has undergone any physical therapy since the surgery of 08/2009. And, indeed, all conservative measure should be exhausted prior to a lumbar fusion. Also, the provider mentions the severe disc space collapse since the surgery of 08/2009. However, this is not noted in the MRI report submitted for review. No plain films of the lumbar spine were submitted for review, as well. Therefore, based on the submitted documentation, the proposed surgery is not medically necessary.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)