

SENT VIA EMAIL OR FAX ON
Nov/15/2010

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Nov/15/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Laminectomy Lumbar Spine L5/S1; Insert Lumbar Fixation Device L5/S1; Lumbar Posterior Fusion L5/S1; Transforaminal Lumbar Interbody Fusion L5/S1; Apply Lumbar Spine Prosth Device; LUmbar Spine Allograft; Lumbar Spine Autograft; Fluoroscopy; LUmbar-Sacral Orthotic; Inpatient Hospitalization 3 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
01/16/09, 01/22/09
09/13/10, 09/27/10
Dr. PAC 01/13/09, 01/19/09, 01/27/09, 02/11/09, 02/18/09, 10/09/09, 04/06/10,04/28/10,
09/14/10, 10/26/10
05/04/10
Operative Report 01/29/09
ESI 12/15/08
X-ray 12/11/10
MRI 12/12/10, 10/20/10
Hospital 12/11/108
IRO Summary 10/29/10
206 pages from Group 12/17/08 thru 10/29/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female injured on xx/xx/xx when she lifted boxes and twisted. She developed back and right leg pain with associated numbness. An MRI on 12/11/08 showed an L5-S1 right disc extrusion contacting the S1-2 nerve root. On 01/29/09, the claimant had a right L5-S1 discectomy and nerve decompression. She had initial good results with resolution of her right leg pain although there was residual numbness.

On 10/09/09, the claimant saw Dr. for return of the back and right leg pain. She had limited motion and straight leg raise on the right causes back and right proximal leg pain. There was decreased sensation of the lateral calf that was present preoperatively. X-rays showed significant narrowing at L5-S1 with slight additional narrowing since surgery. Dr. recommended fusion, but this was denied. A 04/06/10 note from Dr. reported she had increased low back pain. The examination was unchanged. Again, Dr. recommended fusion be considered.

A 05/04/10 psychological evaluation voiced concerns regarding surgery at that time due to depression, substance abuse and personality disorder.

A 09/27/10 peer review noted there had been treatment after psyche evaluation and she was apparently cleared. The reviewer also noted there had been an RME with reported 2/5 Waddell's. Dr. felt the fusion was needed due to complete loss of disc space. The request was denied as there had not been a recent MRI or flexion/extension x-rays.

On 10/20/10, a MRI of the lumbar spine with and without contrast was performed. There was L2-3 desiccation and L3-4 mild facet degeneration. At L4-5 was a disc bulge and mild facet changes. There was an L5-S1 right paracentral disc protrusion and mild facet degenerative changes, mild right neural foraminal stenosis and the prior right laminectomy.

At the 10/26/10 visit, Dr. documented that straight leg raise on the right was positive at 25 degrees with pain to the right foot. There was decreased sensation in the lateral calf and the right Achilles reflex was absent. He reviewed the films and though the MRI scan showed an L5-S1 protrusion and foraminal stenosis; he went on to note that there was retrolisthesis identified by the radiologist. X-rays showed L5-S1 severe narrowing. The impression was recurrent disc herniation, L5-S1 retrolisthesis, discogenic pain with disc collapse and previous L5-S1 Discectomy. L5-S1 fusion was recommended.

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

The request is for laminectomy lumbar spine L5/S1; Insert lumbar fixation device L5/S1; Lumbar posterior fusion L5/S1; Transforaminal lumbar interbody fusion L5-S1; Apply lumbar spine prosthetic device; Lumbar spine allograft; Lumbar spine autograft; fluoroscopy; Lumbar-sacral orthotic; Inpatient hospitalization three days medically necessary.

The claimant has undergone prior surgery; there is no documented instability. It is unknown if they are recommending an artificial disc with the prosthesis, and pain generators were not identified. Therefore, the request is not medically necessary.

Official Disability Guidelines Treatment in Worker's Comp, 15th edition, 2010 Updates
Low Back

Patient Selection Criteria for Lumbar Spinal Fusion:

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)