

SENT VIA EMAIL OR FAX ON
Sep/22/2010

Applied Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/20/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 day LOS for laminectomy fusion L5-S1 surgery

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

08/12/10, 08/19/10, 08/23/10

Dr. 06/03/10, 07/26/10, 08/16/10

CT/myelogram 06/23/10, 06/14/08

MRI 06/09, 06/27/08, 09/23/08, 12/18/08

Peer Review MRI 08/11/10, 08/23/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male injured on xx/xx/xx when he slipped in the mud. He had back and right leg pain with a subsequent right L5-S1 laminectomy in 02/09. Following surgery, the patient had persistence of the low back and right leg pain. Treatment included hydrocodone, Robaxin and epidural steroid injections at some point.

On 06/03/10, Dr. evaluated the patient for ongoing severe mechanical back pain and right leg pain. The examination documented decreased motion in all planes and right leg pain with flexion. There was paralumbar tightness, loss of lordosis and an antalgic gait. Reflexes were trace at the knees and left ankle but absent in the right ankle. Straight leg raise was positive on the right at 30-45 degrees and on the left at 45-60 degrees. The claimant had decreased sensation of the right S1 including the lateral right foot with weakness of the right foot and great toe flexion

The 06/23/10 myelogram showed narrowing at L5-S1 with a central defect. The CT of the lumbar spine documented no abnormality T12-L4. At L4-5 and L5-S1 there was no clear evidence of a disc or central stenosis. He had mild disc space narrowing at L5-S1. There was no motion on flexion, extension or lateral views.

The claimant returned to Dr. on 07/26/10. Dr. reviewed the CT myelogram and felt it showed narrowing at L5-S1 with a central defect. Based on the severe mechanical back pain due to diskopathy and radiculopathy, Dr. recommended posterior decompression and fusion at L5-S1. Surgery was denied on two peer reviews.

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

The request for L5-S1 posterior decompression and fusion with a one-day length of stay cannot be recommended as necessary. The records submitted for this review lack detailed documentation of any recent conservative management other than Hydrocodone and Robaxin as recommended by the guidelines. While there was notation of epidural steroid injections, it is unclear as to when these were provided. There is nothing to suggest that the injections were recent or that the claimant has had other treatment such as therapy.

The Official Disability Guidelines do not support spinal fusion in the absence of conservative management. In addition, ODG does not recommend fusion in the absence of instability. The CT myelogram dated 06/23/10 does not show any abnormal motion of the lumbar spine and there is no definite herniation or stenosis that might require a decompression procedure. There is reported weakness of the right foot and an absent right Achilles reflex but it is not clear whether these are new findings or if they were possibly present prior to the 2009 laminectomy. Finally, the records do not demonstrate that the claimant has had a psychological evaluation to address any confounding issues preoperatively.

Based on a care review of all the information submitted, the request for L5-S1 decompression and fusion cannot be recommended as necessary.

Official Disability Guidelines 2010, Low Back-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)