

SENT VIA EMAIL OR FAX ON
Dec/23/2010

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Dec/23/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Two (2) day inpatient length of stay (IP LOS) for L4/5 laminectomy, discectomy, arthodesis with cages and posterior instrumentation

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D. who is 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

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have sustained work related injuries to her low back on xx/xx/xx. She is reported to be employed as and on the date of injury she had to constantly carry 25 lb boxes from her trunk. She subsequently developed sharp shooting pain in her back on right side with radiation into right groin area with later development of right leg pain.

The first available clinical record is dated 08/25/09. On this date she presented to Dr.. Dr. documents the mechanism of injury above. She is reported to have previously gone to physical therapy and felt a lot of relief; however, she was only approved for a few visits. She was reported to be intolerant of most medications. On physical examination she is reported to be in no apparent distress. On examination gait and station are normal. She is noted to have paraspinal muscle spasms bilaterally. There is tenderness to palpation over the lumbar midline as well as the bilateral paravertebral musculature and bilateral SI joints. She is reported to have palpable trigger points over the paravertebral musculature. Range of motion is limited secondary to pain. Both flexion and hyperextension are painful. Left and right

lateral bending is painful. She is reported to have positive Patrick's and Faber's test bilaterally. Kemp's is positive bilaterally. Straight leg raise is positive producing concordant pain in L5-S1 distribution. Muscle strength is 5/5 in all groups except 4/5 in lower extremity quads and hamstrings bilaterally. She is reported to have decreased sensation in L4, L5 and S1 distributions. MRI of the lumbar spine dated 08/05/09 was reviewed. This study notes a central disc protrusion at L4-5 with canal and neural foraminal compromise secondary to associated posterior element osteoarthritis. She is reported to have neural impingement of the L4 and L5 nerve roots bilaterally. The claimant subsequently underwent a lumbar epidural steroid injection on this date. She was prescribed the medications Voltaren gel and Meloxicam. She underwent additional epidural steroid injection on 09/14/09 with a 3rd injection on 10/14/09.

The claimant was subsequently seen in follow-up on 09/21/09. The record suggests the claimant received 50% relief with these injections. On examination she is reported to have mild antalgic gait. She is reported to have no focal tenderness, spasms or trigger points of lumbar spine. She continues to have decreased range of motion with pain in flexion and extension with no pain on side bending or rotation. Kemp's test was negative. Straight leg raise was positive bilaterally. She continues to have 4/5 strength in quadriceps and hamstrings. Sensory is reported to be decreased in L4, L5, and S1 distributions. She appears to have been scheduled for additional epidural steroid injections.

On 11/11/09 the claimant was referred for EMG/NCV study, which reports evidence of right L5 root injury with evidence of acute denervation of right biceps femoris muscle with no acute paraspinous denervation. Claimant was seen in follow up by Dr. 12/01/09. She reports 40-50% relief of her pain with the previous procedures. It's reported that this has lasted seven weeks. Her current pain level is reported to be 3/10. She's recommended to have additional injections and continued physical therapy. Her physical examination is largely unchanged.

On 04/06/10 the claimant underwent psychiatric evaluation performed. It's reported that the claimant has been under the care of Dr. and has been referred for pre-surgical evaluation. The evaluator reports the history above. Claimant reports that she cried the entire time when undergoing MRI and EMG. Her current medications are Flector Patch with other pain medications. The claimant reports her pain levels are 7/10 without medication and her average daily pain is 5-6/10. She has no history of previous mental health treatment. She is married. She reports that her pain interrupts her sleep. She was administered a Beck depression inventory which was 22 indicating mild depression and a Beck anxiety inventory of 16 indicating mild anxiety. She is opined to be a psychologically sound candidate for surgery.

On 05/03/10 the claimant underwent a functional abilities evaluation. This report indicates that the claimant cooperated fully in all activities. She was reported to have demonstrated consistent performance and reproducible results. She is reported to have been unable to perform all required testing. She's reported to have been unable to walk, stoop, squat, crouch, crawl or bounce/balance/barrel secondary to pain. She was found to be occasionally capable of lifting 35 pounds in all positions and 15 pounds frequently. She's opined to be lifting in the sedentary category.

The claimant underwent a second physical performance evaluation on 05/14/10. She again was found to be capable of lifting 35 pounds occasionally and 15 pounds frequently.

A third physical performance evaluation was performed on 06/08/10. She again was found to be capable of lifting 35 pounds occasionally and 15 pounds frequently.

On 07/05/10 the claimant underwent a repeat psychological evaluation to determine the appropriateness of a chronic pain management program on 07/05/10. It subsequently was recommended that she be involved and participate in an interdisciplinary pain management program.

On 09/09/10 the claimant was seen by Dr. for complaints of right-sided low back pain. She's reported to have complaints of constant pain in the lower back area traveling to the right posterior thigh all the way to her ankle. ADLs make her condition worse. She's been using

medication as needed which has been helpful. She's had two nerve conduction studies done and received two epidural steroid injections from Dr. which only provided temporary relief. She has been seen by Dr. who recommended surgery but reports that this was denied. She's completed 20 sessions of a work hardening program and she's currently been approved for chronic pain management and behavioral pain management program.

On physical examination she is reported to be in no acute distress. She is not utilizing any assistive devices. She has no tenderness or muscle spasms noted with full range of motion of cervical spine and bilateral upper extremities. On examination of the lumbar spine there is pain in right SI joint. Range of motion is restricted. Flexion causes most of the pain. Straight leg raise is positive on right in sitting and standing position. There is diffuse loss of sensation in right posterolateral thigh predominately in L5-S1 nerve distribution. She is reported to have difficulty walking on heel and toe. Deep tendon reflexes are 1+ in bilateral knees and trace to 1+ in left ankle and absent in right ankle. There is generalized weakness in bilateral lower extremities. She is recommended to obtain her entire medical records.

On 09/13/10 the claimant was seen by Dr., D.C. She is reported to have been referred by her treating physician. She is opined to have lumbar strain/sprain complex with lumbar disc herniation at L4-5 producing right L4-5 radiculopathy.

The claimant was seen in follow-up by Dr. on 09/30/10. She reports paresthesias in right lower extremity. She notes difficulty walking and climbing stairs. A previous work hardening program improved her pain partially. She has been previously recommended for surgery, which has been denied. She would like to have second opinion from surgeon. On physical examination she is reported to have decreased range of motion and some decreased sensation in right L5-S1 nerve distribution with difficulty standing on heel and toe during repetitive activities.

She subsequently was referred to Dr. for evaluation and second opinion. It is further noted she has been to a designated doctor.

On 10/26/10 the claimant was seen by Dr. She is reported to be ambulatory with slight antalgic gait to right side. She is reported to have failed conservative treatment consisting of exercise program, medications, epidural steroid injections, and chronic pain management evaluation. She is reported to have workup including EMG/NCV, which is reported as normal for her right L5 nerve root. She has had multiple epidural steroid injections with no improvement. She has had a second surgical consultation with neurosurgeon Dr. who recommended surgery. Radiographs of pelvis revealed no degenerative joint disease. The sacroiliac joints are without sclerosis. It is reported that radiographs of her lumbar spine including flexion and extension views revealed two point instability at L4-5 with coronal plane functional spine unit collapse with anterior column lack of support collapsing down to 6 mm with normal measuring 12. She is reported to have a lack of posterior column support with facet subluxation and foraminal stenosis. She is reported to have rotational collapse to right of 4 mm and to left of 9 mm. Dr. opines 2 point instability at L4-5 is defined by AOS. On physical examination she is reported to have positive spring test, positive sciatic notch tenderness on right, positive extensor lag, positive flip test on right, positive Lasegue's on right at 45 degrees contralateral, positive straight leg raise on left at 75 degrees, positive Braggard's on right, absent posterior tibial tendon jerks, decreased knee jerk on right, decreased ankle jerk on right, weakness of EHL tibialis anterior, with positive extensor lag. Dr. opines the claimant has clinical instability at L4-5 with failed conservative treatment primarily right-sided radiculopathy. He subsequently recommends decompressive lumbar laminectomy, discectomy and arthrodesis with internal fixation and reduction of subluxation of her 2-point instability at L4-5 and both sagittal and coronal planes.

The case was initially reviewed by Dr. on 11/19/10. Dr. notes that the claimant is 18 months post date of injury and she has not improved despite extensive treatment. He notes the claimant has MRI evidence of neurocompression and instability. He noted the only objective testing presented is MRI that is 15 months old. He notes it would be prudent to obtain current imaging of spine prior to surgery. He recommended the requested MRI as needed for surgical planning. He subsequently non-certifies the request for lumbar fusion given the lack of appropriate documentation.

On 12/02/10 the request was evaluated by Dr. Dr. notes the claimant sustained an injury on xx/xx/xx and she has undergone extensive conservative treatment and continued complaints of low back and right lower extremity pain. He reports on examination she has positive straight leg raise on right at 45 degrees and on the left at 75 degrees. The claimant has weakness of the right EHL and diminished right ankle jerk. Studies done to date include EMG/NCV on 11/11/09 which showed signs of right L5 nerve root irritation and MRI on 08/05 showed central L4-5 protrusion with impingement of bilateral L4-5 nerves. He notes the claimant has previously undergone psychological evaluation. He notes the procedure was denied earlier this month because the examiner felt MRI performed in 08/09 needed to be updated. He reports there is no evidence this has been completed. He further notes that clinically the claimant does appear to have signs of a right L5 nerve root irritation but does not appear to fulfill the ODG requirements for surgical fusion. Therefore, the request is denied.

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

The submitted clinical records indicate the claimant is a female who is reported to have sustained an injury to her low back as a result of lifting boxes. The records indicate the claimant has undergone extensive conservative treatment consisting of oral medications, physical therapy, and lumbar epidural steroid injections with no improvement. The record contains a single MRI dated 08/05/09. This study is dated and reports that at L4-5 there is a central disc protrusion with canal and neural foraminal compromise secondary to associated posterior element osteoarthritis with neural impingement of the L4 and L5 nerve roots bilaterally. This study does not indicate any significant level of disc desiccation or collapse of the disc spaces. The records further indicate the claimant underwent EMG/NCV study on 11/11/09 which indicates the claimant has evidence suggestive of right L5 nerve root compromise consistent with the claimant's imaging study. The claimant subsequently has undergone two psychological evaluations, one for surgery in which he was cleared, and the second for participation in chronic pain management program. She is noted to have completed a course of work hardening with subjective reports of improvement in pain levels. She does not appear to have participated in chronic pain management program, which is a tertiary level program. The claimant's most recent physical examinations indicate evidence of right L5 radiculopathy consistent with imaging studies. She was referred to Dr. for 2nd/3rd opinion. Dr. reports performing lumbar flexion / extension radiographs and the claimant has two plane instability at L4-5 level; however, he does not indicate the claimant has any anterior or posterior instability per ODG and AMA guidelines. Dr. suggests the claimant has collapse of disc space, which is not evident on previous imaging study. She is noted to have findings consistent with right L5 radiculopathy, which would be consistent with imaging studies.

Previous reviewers have denied the performance of fusion secondary to dated imaging studies. The IRO reviewer would concur the claimant's imaging studies are dated and would further note the record does not include independent lumbar flexion and extension radiographs establishing anterior and posterior translation per ODG and AMA guidelines. As such, there is no objective evidence presented of instability. The appeal reviewer notes the claimant does not meet criteria for fusion, which is correct based upon submitted data. He further notes the claimant may be candidate for lesser surgery; however, this has not been proposed. As such, the previous two determinations by the reviewing physicians are appropriate and consistent with ODG guidelines, and the IRO reviewer would concur with these decisions and recommend the request is not medically necessary.

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)