

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: June 16, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar laminectomy and discectomy and possible Aspen fusion at the L5-S1 level and possibly at the L4-L5 level, with one day inpatient length of stay following surgery. CPT Codes: 22630.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

AMERICAN BOARD OF NEUROLOGICAL SURGERY

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

Medical records from the Carrier include:

- 09/28/10, 03/04/11
- Treatment Center, no date, 11/08/10
- Consultants, Associates, no date
- Imaging, no date, 10/11/10, 10/22/10
- Employer's First Report of Injury or Illness, 09/29/10
- = Treatment Clinic, 09/28/10, 10/05/10, 09/29/10, 09/30/10, 10/01/10, 10/06/10, 10/11/10, 10/13/10, 10/15/10, 10/18/10, 10/20/10, 10/20/11, 10/22/10, 10/25/10, 10/28/10, 11/04/10, 11/20/10, 11/22/10, 11/24/10, 11/28/10, 11/30/10, 12/01/10, 12/06/10, 12/07/10, 12/14/10, 12/21/10, 12/22/10, 12/23/10, 12/27/10, 12/28/10, 12/29/10, 12/30/10, 01/03/11, 01/04/11, 01/05/11, 01/07/11, 01/14/11, 01/20/11, 01/28/11, 02/28/11, 03/28/11, 04/27/11
- East Medical Center, 09/25/10
- Texas Workers' Compensation Work Status Report, 09/28/10, 10/28/10, 11/30/10, 12/29/10, 01/10/11, 01/28/11, 02/01/11, 02/28/11, 03/04/11, 03/28/11, 04/19/11, 04/28/11, 05/03/11
- D.C., 09/28/10, 04/11/11
- 10/11/10, 10/29/10, 11/22/10, 12/14/10, 12/15/10, 12/22/10, 01/12/11, 01/14/11, 01/25/11, 02/24/11, 02/28/11, 03/23/11, 03/28/11, 04/08/11, 05/18/11
- M.D., 10/26/10, 01/10/11, 02/01/11, 05/03/11
- 11/16/10, 01/25/11, 01/31/11, 02/03/11, 02/09/11, 02/14/11, 02/18/11, 03/01/11, 03/02/11, 03/03/11, 03/07/11, 03/08/11, 03/14/11, 03/15/11, 03/16/11, 03/25/11, 03/28/11, 03/30/11, 03/31/11, 04/01/11, 04/04/11, 04/05/11, 04/06/11, 04/07/11, 04/11/11, 04/19/11
- M.D, 12/02/10

- Services, Corporation, 12/21/10, 01/20/11, 01/31/11, 02/21/11, 04/21/11
- Surgery Center, 01/21/11
- M.D., 03/04/11

Medical records from the URA include:

- Official Disability Guidelines, 2008
- 05/27/11
- Request for a Review by an Independent Review Organization, 05/26/11
- M.D., 10/26/10, 01/10/11, 04/19/11, 04/26/11, 05/03/11, 05/11/11
- Imaging, 10/22/10
- M.D, 12/02/10
- 04/29/11, 05/18/11

Medical records from the Provider include:

- 05/27/11
- Imaging, 10/22/10
- M.D., 10/26/10, 01/10/11, 02/01/11, 04/19/11, 05/03/11
- M.D., 12/02/10

PATIENT CLINICAL HISTORY:

The description of service or services in dispute is laminectomy and discectomy with possible Aspen fusion at L5-S1 and L4-5.

The description of qualifications for the physician who reviewed the decision is board certified neurosurgeon.

The review outcome of laminectomy and discectomy with Aspen fusion at L5-S1 and L4-5 decision is upheld.

This is a male with a date of injury on xx/xx/xx, when he was lifting a heavy object. The patient complained of back, as well as severe radiating leg pain to the toes. The patient has undergone physical therapy, chiropractic therapy, epidural steroid injections, pain medication, and chronic pain management.

An MRI of the lumbar spine was performed on October 22, 2010. At L4-5, there was a broad-based 0.2 cm disc herniation and ligamentum flavum hypertrophy that flattened the thecal sac. There was also advanced bilateral neuroforaminal narrowing with impingement on the L4 nerve roots bilaterally. At L5-S1, there was a 0.2 cm disc herniation that flattened the thecal sac. There was bilateral foraminal narrowing with impingement of the L5 nerve roots. There was mild L2-3 and moderate L3-4 bilateral neuroforaminal narrowing.

An EMG/NCV study on December 2, 2010, reveals evidence of acute bilateral L5 and S1 radiculopathies.

On May 3, 2011, the patient revealed positive straight leg raising on the right and reduction of pinprick sensation in the right leg.

The provider is recommending a laminectomy and discectomy with Aspen fusion at L5-S1 and L4-5.

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

The proposed surgery is not medically necessary. While the patient has evidence of radicular symptoms, it is unclear why a decompression alone would not alleviate the majority of his symptoms.

The patient does not have significant spondylosis or spondylolisthesis at L4-5 and L5-S1. In addition, is an Aspen spinous process fixation system would be considered experimental/investigational as this has not been well-studied in the peer-reviewed medical literature. For these reasons, the surgery is not medically necessary. According to the ODG, Low Back Chapter, indications for a lumbar fusion included spondylitic/spondylolisthesis one or two-level segmental failure with progressive degenerative changes, loss of height, disc loading capability, and segmental instability. The patient's condition does not appear to meet these criteria. Therefore, the surgery is not medically necessary.

References: ODG, Low Back Chapter, 16th Edition, patient's selection criteria for lumbar fusion.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)