

SENT VIA EMAIL OR FAX ON
Apr/21/2011

Applied Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Apr/21/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
DME LSO, Sagittal Control, Rigide Ant and Post Panels Prefab

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

1. Utilization review determination dated 03/14/11
2. Utilization review determination dated 03/30/11
3. Spinal orthosis evaluation form
4. Prescription dated 01/26/11
5. Clinical records Dr. dated 05/15/03 through 03/07/11
6. MRI of the lumbar spine dated 02/01/11
7. Clinical note Dr. dated 03/05/09

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male who is reported to have sustained work related injuries on xx/xx/xx as a result of an apparent lifting injury. Clinical records indicate that the injured employee underwent surgery for a herniated lumbar disc on 07/29/06. He is reportedly improved but continues to have symptoms of leg and low back pain. It's reported in 2007 he had an epidural steroid injection and received partial improvement. The injured employee

has been followed by Dr. since 2005.

On 03/05/09 the injured employee was seen by Dr.. It's reported that one the date of injury the injured employee was lifting a butane gas tank weighing approximately 200 pounds when he developed low back pain. He was seen by Dr. who performed surgical treatment at the L4-5 level and he did fine for 10 years after surgery. However his condition began to worsen. As of this date the injured employee has low back pain with radiation into the foot greater on the left side. On examination he's reported to have a positive straight leg raise at 60 degrees, decreased sensation in the left S1, and decreased reflexes in the lower extremities. He's able to heel toe walk. MRI done on 11/20/08 revealed L3-4 left lateral protrusion with foraminal narrowing, L4-5 protrusion versus scar tissue and L5-S1 right protrusion. It's recommended that he have a new MRI of the lumbar spine. He may require a surgical procedure.

On 01/26/11 it is reported that the injured employee continues to have sciatic pain for the last month and a half which has increased. He is unable to walk, unable to stand without a walker. Straight leg raise is reported to be positive. There's decreased range of motion of dorsiflexion of the left foot and paresthesias down the legs. He's recommended to undergo MRI of the lumbar spine.

On 02/01/11 the injured employee underwent MRI of the lumbar spine. T12 through L2-3 is reported as normal. At L3-4 there's a left lateral foraminal disc protrusion encroaching into the left neural foramen which may be affecting the exiting left L3 nerve root or descending left L4 nerve root. This is essentially stable since his prior examination. There are additional degenerative disc changes present consisting of disc space narrowing and intervertebral desiccation. At L4-5 there's a left foraminal lateral disc extrusion with a small fragment noted in the anterolateral aspect of the thecal sac on the left likely impinging on the descending left L5 nerve root. This small disc fragment measures 8mm in greatest cranial caudad dimension by 6mm in anterior posterior dimension. There are additional degenerative disc changes. There's mild to moderate ligamentum flavum hypertrophic changes and hypertrophic facet changes. At L5-S1 there's no evidence of disc herniation. Hypertrophic facet changes are present. The injured employee was subsequently seen in follow up by Dr. The injured employee is recommended to undergo surgical intervention. Records indicate that a lumbosacral orthosis was prescribed.

On 03/14/11 the request was reviewed by Dr.. Dr. notes that the injured employee has been prescribed a lumbosacral orthosis to be used for 12 months. He notes that the injured employee had unspecified surgery at L4-5 in 1996. The injured employee has been recommended to have spinal immobilization in view of his L4-5 and L5-S1 disc herniation. Dr. opines that the need for spinal immobilization was not adequately substantiated in the absence of flexion extension x-ray studies objectively demonstrating evidence of a spinal instability. He notes that report dated 03/07/11 does not make any reference regarding the requested lumbosacral orthosis or clarify the timing of his use in reference to contemplated surgery. He subsequently finds that the request is not medically necessary.

The peer request was reviewed by Dr. on 02/30/11. Dr. notes acknowledgment of the previous non-certification due to lack of documentation of flexion / extension x-rays. Studies objectively demonstrate evidence of spinal instability. He notes the injured employee complains of low back pain with sciatic pain. There is a positive straight leg raise on left and contralateral Lasegue's sign. He notes there is no documented instability, and therefore, medical necessity has not been fully established. Dr. non-certified the request.

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

The request for DME LOS, Sagittal control, rigid anterior and posterior panels prefab is not supported by the submitted clinical information. The previous utilization review determinations are upheld. The submitted clinical records indicate the injured employee is status post a lumbar discectomy at L4-5 level with apparent 10 years of relief. The injured

employee has developed progressive low back pain. Most recent imaging studies indicate disc herniations at the L3-4 and L4-5 level. The submitted clinical records do not provide any data to suggest the injured employee has exhausted conservative treatment and is a surgical candidate for performance of fusion and would require postoperative LSO. The records do not include lumbar flexion / extension radiographs establishing the injured employee has instability. Noting that there is no specific surgical treatment plan and there is a lack of documentation to establish instability the Official Disability Guidelines would not support the use of an LSO. The ODG notes LSO are not recommended for prevention and they are under study for treatment of non-specific low back pain. LSO are recommended as an option for compression fractures and the specific treatment of spondylolisthesis documented instability or post-operative treatment. The available records indicate that the injured employee meets none of these categories and therefore the previous adverse determinations are upheld.

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)