

SENT VIA EMAIL OR FAX ON
Nov/1/2011

Applied Assessments LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/31/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4/5 Revision Lumbar Laminectomy, Discectomy, Fusion and Instrumentation, Implantable Bone Growth Stimulator, 2 day Inpatient Stay

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

Board Certified Orthopedic Spine Surgeon, Practicing Neurosurgeon

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 male who is reported to have sustained an injury to his low back on Xx/xx/xx. On this date he was reported to have injured his low back while lifting a 5 gallon container of water. He developed low back pain with radiation into right lower extremity. He underwent initial surgery in 07/08 and subsequent re-rupture and second surgery in 02/09. Postoperatively he had foot drop on right side with persistent pain and paresthesias down

right leg. He is reported to have developed terminal urinary dribbling and urgency as well as sexual dysfunction since his injury. He has history of diabetes controlled with oral agents. He was referred for EMG/NCV study on 05/03/10. He is noted to have evidence of L4-S1 radiculopathy bilaterally with right side predominating with acute irritability noted in S1 nerve roots without denervation. The greatest reduction with reinnervation changes were seen in right L5 distribution. There is significant conduction delays which may be due to diabetic neuropathy. It is noted there is significant involvement of lower sacral S2-S4 motor roots bilaterally by external anal sphincter sampling consistent with urinary and sexual dysfunction following his injury. The record contains an MRI of the lumbar spine dated 05/11/10. This study notes disc desiccation and mild changes of lumbar spondylosis at L2-3 and L3-4. There is no focal disc herniation or substantial required spinal canal stenosis present. There is a developmentally small lumbar spinal canal. There is degenerative disc disease at L4-5 with mild bulging of the disc. There is mild asymmetrical protrusion of the disc along the right paracentral disc margin unchanged significantly since prior study performed on 05/02/09. This produces a mild impression on the anterior thecal sac, and prior right sided laminectomy appears to have been performed. There is degenerative facet disease at L5-S1. Radiographs of lumbar spine performed on 06/03/10 including flexion / extension views showed disc space narrowing at L4-5 with anterior and posterior degenerative spurring. These findings are consistent with fairly severe degenerative disc disease. There is anterior degenerative spondylosis at L1-2, L2-3 and L3-4. There is no spondylolisthesis present. There is some moderate left lateral and right lateral degenerative spondylosis at L2-3. Records indicate the claimant was followed by Dr. for his urologic complaints.

The record includes a post designated doctor's required examination in which the evaluator finds the claimant had reached maximum medical improvement on 04/26/10. He notes the claimant cannot really be rated as having a cauda equina syndrome, but does have bowel and bladder abnormalities. He notes after two surgeries there is apparent damage to spinal cord. He notes there are complicating issues because the patient is a diabetic. He has low testosterone. He notes the issue is complicated because 66% of patients who are diabetic and 50 years of age have erectile dysfunction.

On 03/24/11 the claimant was seen by M.S., L.P.C. for psychological evaluation. He is noted to have complaint of mood disturbances, anxiety, sleep disorder, erectile sexual dysfunction, psychosocial stressors, and physical limitations. The claimant is noted to have mild to moderate depression, mild to moderate anxiety, significant feelings of disability. He subsequently was recommended to undergo individual psychotherapy.

On 05/25/11 the claimant was seen by Dr. He notes the claimant is status post laminectomy at L4-5 and has inconsistent physical examination with breakaway strength. He is recommended to undergo EMG/NCV studies. There is a possibility he may require nerve block at L5 on the right. He has failed back surgery syndrome. He was given an air splint for right ankle due to possibility of loss of strength in right ankle and eversion. MRIs were discussed. The claimant is to be seen in follow-up for pain management.

On 08/16/11 the claimant was seen by Dr. Dr. notes the claimant has diagnosis of post lumbar laminectomy syndrome, status post lumbar surgery x 2 with back pain and right leg pain. He notes there is no change in his pain. He has episodes of spasms involving the right leg. He walks with assistance of cane. Straight leg raise on right produces low back pain, buttock and thigh pain. Imaging studies were discussed. His condition is opined to be stable.

The claimant was ultimately referred to Dr. on 09/06/11. The claimant is reported to have bilateral leg pain and right leg weakness, incontinence of bowel and bladder. The claimant is 6'2" tall and weighs 365 lbs and presents for surgical consultation. He further notes the claimant is status post lumbar laminectomy and discectomy x 2 and status post anterior cervical decompression and discectomy and instrumented arthrodesis in 2003. He discusses his electrodiagnostic studies. Radiographs of lumbar spine including flexion / extension views are reported to show functional spine collapse from 13 mm to 5.5 mm on standing for total collapse of 7.5 mm. He further indicates posterior column deficit, facet subluxation, foraminal stenosis, and opines the claimant meets functional spinal unit collapse criteria per

ODG and requires stabilization. On physical examination he is reported to have well healed midline incision, positive extensor lag, mild paravertebral muscle spasm, positive sciatic notch tenderness worse on right, positive flip test, positive Lasegue's, positive straight leg raise on left at 75 degrees, positive Braggard's on the right, hypoactive knee jerk on right, absent posterior tibial tendon jerks bilaterally, weakness of tibialis anterior extensor hallucis longus on right, paresthesias in L5 nerve root bilaterally, S1 nerve root distribution on right and no atrophy. He is opined to have failed lumbar spine syndrome with clinical instability and partial cauda equina syndrome. He is recommended to undergo revision lumbar spine surgery with total laminectomy, decompression, discectomy and instrumented arthrodesis at L4-5.

The initial review was performed by Dr. Dr. non-certified the request noting the claimant's physical examination does not correlate with MRI findings. Previous lumbar flexion / extension radiographs showed no pathological movements.

A subsequent appeal request was reviewed by Dr. Dr. indicates the claimant is over 3 ½ years post date of injury. He has had prior surgery with Dr. He noted that Dr. saw the claimant on 08/16/11 and indicated the claimant was stable and did not propose any further spine surgery. It is further reported that Dr. found no urinary incontinence and Dr. agrees with this. He notes the claimant has no instability but does have multilevel spondylosis. He indicated further spine surgery is not validated by the records.

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

The request for L4-5 revision lumbar laminectomy, discectomy, fusion and instrumentation, implantable bone growth stimulator and 2 day inpatient stay is not supported by the submitted clinical information. The available medical record indicates the claimant sustained an injury to his low back on xx/xx/xx. He has history of two prior spinal surgeries with no significant improvement, and per the clinical record, significant residuals include foot drop and bowel and bladder issues. There is no clear documentation to establish diagnosis of cauda equina syndrome. It is noted on 06/03/10 the claimant underwent independent lumbar flexion / extension radiographs which showed no evidence of abnormal movement. The claimant is noted to have multilevel degenerative changes. He has comorbid diabetes which would clearly impact his neurologic dysfunction. The claimant has been followed by his treating surgeon Dr. who has not recommended any additional surgeries. He is noted to weigh over 300 lbs placing the claimant at exceedingly high risk for any future surgical interventions. The claimant has also undergone psychological evaluation on 03/24/11 which recommended at least 6 sessions of individual psychotherapy. There is no indication the claimant has been released from this treatment. Based on the totality of the clinical information, the claimant does not meet criteria per ODG, and noting his history of previous response to prior surgeries and morbid obesity, the claimant would not be considered appropriate or safe surgical candidate.

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)