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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Nov/21/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient anterior/posterior fusion and bilateral laminectomy at L5/S1 with possible two (2) to three (3) days length of stay (LOS)

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

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

IRO request/referral documents

Notice of utilization review findings 09/14/12

Notice of utilization review findings 09/28/12

Pre-authorization request 09/10/12

History and physical 03/02/12-09/14/12

Neurosurgical consultation report 08/12/11

Lumbar CT myelogram 08/02/12

MRI lumbar spine 06/15/12 and 07/29/11

X-rays lumbar spine 07/05/11

Lower extremity neurodiagnostic test 11/21/11

Office notes 11/01/11 and 09/22/11

Lumbar spine x-rays 02/04/11

Pre-surgical health and behavioral evaluation 08/22/12

Rehabilitation progress notes and reevaluation 05/29/12-06/04/12

Office notes 06/04/12

Notice of intent to issue adverse determination 05/07/12

Notice of utilization review findings 09/01/11

Pre-authorization reconsideration request 09/20/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female whose date of injury is xx/xx/xx. Records indicate she was injured when she slipped and fell on snow and ice. She complained of low back pain radiating into the bilateral lower extremities, right greater than left. MRI of the lumbar spine dated 07/29/11 revealed an L5-S1 central protrusion which mildly impressed the thecal sac without significant stenosis or focal nerve root displacement. At L4-5, there was a disc bulge with left lateral protrusion and mild lateral recess stenosis, and left sided foraminal stenosis which mildly impressed on the left L4 nerve root. Repeat MRI on 06/15/12 revealed no significant interval change since 07/29/11. X-rays of the lumbar spine from 07/05/11 revealed no acute fracture or subluxation. CT myelogram was performed on 08/02/12 and revealed a 2mm posterior disc protrusion at L4-5 which mildly impinged upon the thecal sac and mildly narrowed both lateral recesses. There was a 4mm posterior central disc protrusion at L5-S1 which mildly impinged upon the thecal sac and both of the S1 nerve root sheaths. Protrusion also moderately narrowed both lateral recesses. There was minimal degenerative spondylosis from L1-2 through L5-S1, and mild degenerative joint and mild degenerative facet joint hypertrophy from L1-2 through L5-S1. The records indicate the claimant has been treated conservatively with medications, chiropractic care, physical therapy, epidural steroid injection, and sympathetic block. Physical examination on 09/14/12 reported the claimant to be 61 inches tall and 207 pounds. His gait was antalgic. There was midline tenderness in the lower lumbar. There was tenderness to palpation and guarded posture. The claimant ambulates with a cane. Motor strength was 5/5 throughout, except 4/5 gastrocnemius bilaterally, EHL, and anterior tibialis of the left lower extremity. Sensation was decreased bilaterally at L4-5 and S1 on the left. Psychological evaluation dated 08/22/12 determined the claimant to be an appropriate candidate for spinal surgery.

A request for inpatient anterior/posterior fusion and bilateral laminectomy at L5-S1 with possible two to three days length of stay was non-authorized per utilization review findings dated 09/14/12. It was noted that the claimant did not meet guidelines for the procedures requested. The neurological examination findings have changed over time and from examiner to examiner. The findings did not correlate with the MRI results or for the requested surgical levels. Finally, all pain generators had not been identified, no instability had been documented, and psychological screening had not been recorded. Therefore, medical necessity had not been established.

An appeal request for inpatient anterior/posterior fusion and bilateral laminectomy at L5-S1 with possible two to three days length of stay was not authorized per utilization review findings dated 09/28/12. It was noted the MRI report provided for review did not support an L5-S1 pathology of such significance that would require such a wide decompression, as the foramina are noted to be patent bilaterally or as the foramina are noted to be patent bilaterally with moderate lateral recess narrowing, and the disc protrusion only mildly impinged on the thecal sac. The recommendation was non-certification of the proposed surgical procedure as the imaging studies of the claimant did not indicate pathology of such a nature that would require the procedure indicated or the procedure requested.

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

Medical necessity is not established for the proposed inpatient anterior/posterior fusion and bilateral laminectomy at L5-S1 with possible two to three days length of stay. The claimant slipped and fell on an icy parking lot on 02/11. She complained of low back pain radiating to the bilateral lower extremities, right greater than left. She underwent a course of conservative care without significant improvement. Imaging studies revealed L5-S1 central protrusion which mildly impresses the thecal sac without significant stenosis or focal nerve root displacement. There is no evidence of subluxation of the lumbar spine, and no evidence of motion segment instability on flexion extension films. The claimant was cleared for surgery from a psychological perspective; however, the pathology identified on imaging studies does not warrant the extensive decompression and fusion surgery as proposed. Consequently, Official Disability Guidelines criteria are not met for medical necessity, and the proposed surgical procedure is not recommended as 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)