

Becket Systems

An Independent Review Organization
815-A Brazos St #499
Austin, TX 78701
Phone: (512) 553-0360
Fax: (207) 470-1075
Email: manager@becketsystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/20/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar laminectomy (hemilaminectomy)/discectomy, additional level decompression, microdissection technique, arthrodesis, lateral (2), application of intervertebral biomechanical device, posterior non-segmental instrumentation (2), anterior lumbar arthrodesis, use of invasive electrical stimulator, implantation of EBI stimulator, reduction of spondylolisthesis-lumbar, anterior lumbar arthrodesis, additional level, reduction of spondylolisthesis, additional level

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

M.D., Board Certified Orthopedic 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

Official Disability Guidelines
Preauthorization determination 01/06/12
Preauthorization determination 01/24/12
Surgical consultation 02/01/11 and 03/24/11
MRI scan review 01/31/11
Individual diagnostic screening / individual psychotherapy 12/22/10
Diabetic neuropathy examination 11/17/09
New patient evaluation and follow-up notes 03/09/10-01/18/11
Procedure note lumbar medial branch block 07/21/10
MRI lumbar spine 02/11/10
Office notes 01/06/11
Clinical lab reports 02/18/10 and 01/22/11
Urine drug screen toxicology reports 04/23/10-12/21/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is xx/xx/xx. He was lifting boxes out of trunk heard a snap and felt throbbing, burning, stabbing pain in lower left side of back. MRI of lumbar spine performed 02/11/10 revealed no occult fractures. At L3-4 there is a 5 mm annular disc bulge flattening the thecal sac and mild narrowing of right interforamen. At L4-5 there is moderate disc space narrowing with 5 mm annular disc bulge, facet joint arthrosis but no bilateral foraminal encroachment. At L5-S1 there is a 4 mm left subarticular disc extrusion abutting the left S1 nerve root sleeve, moderate narrowing of left with minimal narrowing of right neural foramen. The claimant was seen for surgical consultation by on 02/01/11 with chief complaint of back pain and bilateral leg pain worse on left. The claimant reportedly was unresponsive to conservative treatment. The claimant was recommended to undergo

laminectomy, discectomy and instrumentation fusion at L5-S1, with implantable bone growth stimulator.

A pre-authorization review was performed on 01/06/12 and determined that request for lumbar laminectomy, additional level decompression, microdissection technique, arthrodesis, lateral (two), application of intervertebral biomechanical device, posterior mechanical device, posterior non-segmental instrumentation (two), anterior lumbar was non-authorized as medically necessary. MRI from 02/12/10 revealed multilevel degenerative changes with annular disc bulges, facet arthrosis and foraminal narrowing.

At L5-S1 a 4mm left subarticular disc protrusion abuts the left S1 nerve root sleeve; moderate narrowing of the left with mild narrowing of the right neural foramen is present. The claimant has been treated with medications, physical therapy, lumbar medial branch blocks, epidural steroid injections and work conditioning program. He was seen for surgical consultation on 02/01/11, but there were no more recent office notes from submitted for review. An initial psychological evaluation was performed on 12/22/10 and the claimant was recommended to undergo individual psychotherapy. No follow-up psychological evaluations were documented indicating that the claimant has been cleared for surgical intervention. Based on the lack of current clinical data including recent imaging studies such as MRI or plain radiographs with flexion extension views, and noting there was no indication the claimant has been cleared for surgery from a psychological perspective, medical necessity is not established for the proposed surgical procedure.

A pre-authorization review performed 01/24/12 determined the request for lumbar laminectomy, additional level decompression, microdissection technique, arthrodesis, lateral (two), application of intervertebral biomechanical device, posterior mechanical device, posterior non-segmental instrumentation (two), anterior lumbar to be non-authorized. It was noted that the claimant has already been assessed to be at maximum medical improvement by designated doctor and given a 0% impairment rating. It was further noted that the designated doctor reported 5/8 Waddell signs positive.

An IME performed 05/19/10 noted the claimant had diabetic neuropathy and that was the only basis for the reported foot symptoms. He found no basis for any spine surgery as related to the work incident. A radiology review noted three level degenerative disc disorder. It was noted these were not acute injury related findings but degeneration based. A normal neurologic exam was noted on several reports, and even considered the claimant to have facet syndrome. has noted the multilevel disc changes yet his assessment was that the claimant has spinal instability. There was no other documentation by other providers or reviewers. The proposed fusion surgery will be built on an L3-4 disc level that is not normal. The proposed surgery is not consistent with Official Disability Guidelines.

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

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. This patient is noted to have sustained a lifting injury to the low back in 2009. He has undergone conservative treatment including medications, physical therapy, epidural steroid injections and facet medial branch blocks without significant improvement. MRI of the lumbar spine from 02/11/10 revealed multilevel degenerative changes with disc bulges at L3-4 and L4-5 and a left subarticular disc protrusion at L5-S1 abutting the left S1 nerve root sleeve. No updated MRI or flexion extension films with objective evidence of instability of the lumbar spine were submitted. Claimant was seen for surgical consultation by on 02/01/11, with a hand written follow-up note dated 03/24/11. The records do not document that the claimant has been cleared for surgical intervention from a psychological perspective. An initial psychological evaluation on 12/22/10 recommended that the claimant participate in a course of individual psychotherapy and biofeedback sessions. However there is no subsequent psychological assessment indicating that the claimant has been determined to be an appropriate surgical candidate from a psychological perspective. The reviewer finds no medical necessity at this time for Lumbar laminectomy (hemilaminectomy)/discectomy, additional level decompression, microdissection technique, arthrodesis, lateral (2), application of intervertebral biomechanical

device, posterior non-segmental instrumentation (2), anterior lumbar arthrodesis, use of invasive electrical stimulator, implantation of EBI stimulator, reduction of spondylolisthesis-lumbar, anterior lumbar arthrodesis, additional level, reduction of spondylolisthesis, additional level.

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)