

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/13/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

INPATIENT Laminectomy L4-5 Bilateral/ Posterior Interbody Fusion/ Instrumentation

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

M.D., Board Certified 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

Official Disability Guidelines

Adverse determination notice 11/14/11

Adverse determination after reconsideration notice 12/21/11

Clinic note, M.D. xx/xx/xx

MRI lumbar spine 08/30/10

Response to request for IRO 12/30/11

Preauthorization request for inpatient surgery 11/08/11

Preauthorization request for inpatient surgery 12/09/11

Letter of medical necessity M.D. 12/08/11

PATIENT CLINICAL HISTORY SUMMARY

This is a male injured employee whose date of injury is xx/xx/xx. He was lifting an air-conditioner and felt stabbing and burning pain in his back. The injured employee complains of low back and leg pain. MRI of lumbar spine performed on 08/23/10 revealed L4-5 4-5 mm left parasagittal soft tissue disc protrusion / extrusion which extends 3-4 mm below the interspace and touches and effaces the left anterior aspect of thecal sac. There is minimal bilateral foraminal narrowing left greater than right. At L3-4 there is a 1-2 mm shallow broad based annular bulge, which touches and slightly effaces the thecal sac. The foramen and canal appear patent at this level. At L5-S1 a rudimentary disc was demonstrated without significant disc bulge, protrusion or herniation. Dr. saw the injured employee for initial visit on xx/xx/xx. The injured employee reported that back pain hurts worse than buttock / leg pain. The injured employee reportedly had physical therapy 6 months ago without benefit. He also is noted to have undergone epidural steroid injections x 3 without relief. Records indicate the injured employee is taking Norco 10/325 mg tablet 1 every 6 hours as needed for pain. Objective findings revealed the injured employee to be 5'6" tall and 190.6 lbs. Lumbar spine exam reported heel walking normal bilaterally. Toe walk is weak on right and normal on left.

Lumbar range of motion is flexion 10, extension 5, and right and left tilt 10. There is positive tenderness and spasms to paraspinal palpation on right, no tenderness left. Sacroiliac joint palpation notes tenderness on right and no tenderness on left. Sciatic notch palpation is tender on right, negative on left. Knee reflexes are +1 symmetrical. Ankle reflexes are 2+ symmetrically. Babinski is negative. Clonus is negative. Strength is 5/5 in bilateral lower extremities. There is no atrophy present in lower extremities. Sensation is intact to light touch bilaterally. Straight leg raise is negative on left and positive on right. The patient reportedly has instability noted on flexion / extension x-rays at L4-5 or L4 transitional level. He was recommended to undergo decompressive laminectomy with posterior interbody fusion with instrumentation.

Per adverse determination notice dated 11/14/11, the request for inpatient laminectomy L4-5 bilateral / posterior interbody fusion / instrumentation was determined as not medically necessary. The reviewer noted that most recent MD note is 09/22/11. MRI from 08/30/11 fails to reveal any evidence of spondylolisthesis. M.D. notes there are plain film x-rays that note instability; however, x-ray report read by radiologist is not available for review. Given the lack of diagnostic tests supportive of instability or spondylolisthesis, the request was not medically necessary.

Per adverse determination after reconsideration notice dated 12/21/11, request for inpatient laminectomy L4-5 bilateral / posterior interbody fusion / instrumentation was not authorized. The reviewer noted that the indications for spinal fusion as provided and Official Disability Guidelines the reviewer noted that flexion extension dynamic films were not evident; therefore, instability was not established at this time and the requested surgery is not considered medically necessary, as it does not meet stated guidelines.

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

The injured worker is noted to have sustained a lifting injury to the low back on xx/xx/xx. He complained of low back pain radiating to the right buttocks posterior thigh and tingling in the groin area. MRI revealed 4-5mm left parasagittal soft disc protrusion/extrusion with minimal foraminal narrowing bilaterally left greater than right. It is noted that the patient's subjective complaints are of right sided symptoms, and pathology on MRI is to the left. On examination there is no evidence of motor or sensory deficit. Flexion extension radiographs reportedly showed instability at L4-5 or L4 transitional level, but no official radiology report was submitted for review. Also there is no documentation that a pre-surgical psychological evaluation was completed addressing confounding issues. Therefore, the reviewer finds there is no medical necessity for INPATIENT Laminectomy L4-5 Bilateral/ Posterior Interbody Fusion/ Instrumentation. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be 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)