

SENT VIA EMAIL OR FAX ON
Mar/09/2012

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/07/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient L3-S1 revision laminectomy, discectomy, fusion with instrumentation, implantable bone growth stimulator and 2 days inpatient stay

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

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

OD Guidelines

Request for IRO dated 02/22/11

Utilization review determinations dated 01/30/12, 02/10/12 02/22/12

Notice of independent review decision 01/03/12

Clinical Records 02/21/11, 04/12/11, 06/01/11

Treatment records.

Radiographic report lumbar spine 01/10/12

Clinical records 11/08/11, 11/09/11, 12/20/11, 01/31/12,

Behavioral Health Evaluation dated 01/13/12

Procedure Reports dated 09/02/11

Clinical records dated 09/15/11

Clinical Records dated 08/08/11, 09/22/11

MRI cervical spine dated 12/22/10

MRI Lumbar spine dated 05/04/10

MRI review dated 11/09/11

Radiographic report lumbar spine dated 04/29/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who has date of injury of xx/xx/xx. Records indicate the claimant underwent course of conservative treatment and subsequently was taken to surgery by on 02/20/11 at which time he underwent laminotomy, discectomy left side L5-1 with no resolution

of his symptoms. The claimant was subsequently referred for postoperative physical therapy and has been managed by chronic pain management specialist. Records indicate the claimant also has complaints of cervical pain with radiation. The claimant subsequently came under the care of on 11/08/11. At this time notes the claimant had evidence of discal pathology at L3-4, L4-5 and L5-S1 but only received treatment for L5-S1 level. The record includes MRI of lumbar spine dated 05/04/10 which notes slight disc bulge at L2-3. At L3-4 there is a 3 mm broad based disc herniation that impinges along the anterior thecal sac leading to moderate narrowing of bilateral neural foramina. At L4-5 there is a slight disc bulge which indents the thecal sac and leads to mild narrowing of bilateral neural foramina. At L5-S1 there is 7 mm broad based central disc herniation which indents the thecal sac. There is disc space narrowing which leads to mild narrowing of bilateral neural foramina. reports that x-rays of lumbar spine including flexion / extension views reveal L3-4 functional spinal unit failure. He reports measuring 5 mm of collapse with facet subluxation and foraminal stenosis with both anterior and posterior column deficit. L5-S1 standing measures 0-1 mm for collapse at 10 mm associated with facet subluxation, foraminal stenosis, L4-5 standing measures 11 mm. opines L3-4 and L5-S1 meet clinical instability criteria per ODG for functional spine failure. Physical examination indicates he has well healed incision, mild paravertebral muscle spasm, positive sciatic notch tenderness worse on left, negative Fortin finger test, positive extensor lag, positive flip test, positive Lasegue's on left at 30-45 degrees, contralateral straight leg raise on right at 75 degrees, positive Braggard's, hypoactive knee jerk on left, absent posterior tibial tendon jerks bilaterally, absent ankle jerk on left, weakness of gastrocnemius on left, paresthesias in L3, L4 and L5 nerve root distributions on left. He opines the claimant has failed lumbar spine syndrome with adjacent segment disease and instability with failure of conservative treatment. He recommends decompression and arthrodesis at L3-4 and L5-S1 with simple decompression at L4-5. He notes the claimant smokes and subsequently recommends revision of lumbar spine surgery from L3-S1 with global instrumented arthrodesis and implanted bone growth stimulator. The records include interpretation of MRI in which he opines there is non-contained disc herniation stage 3 with annular herniation, nuclear extrusion, spinal stenosis, and desiccation at. At L3-4 and L4-5 there is bulging disc versus contained disc herniation stage 2 with annular herniation, nuclear protrusion and stenosis. He subsequently recommended provocative discography. He reports x-rays on 01/10/12 including flexion / extension views. This study notes severe disc degeneration of L5-S1 with vacuum phenomena. There is 5 mm of retrolisthesis at L5-S1 and both flexion / extension, moderate disc space narrowing at L2-3 and L3-4. There is 3 mm of retrolisthesis in extension and neutral alignment in flexion.

The record includes a notice of IRO dated 01/03/12. The IRO upholds previous denials for proposed inpatient L3-S1 revision laminectomy, discectomy, fusion with instrumentation, and implantable bone growth stimulator with 2 days LOS. The reviewer notes that reports instability of 5 mm in facet subluxation; however, no radiographic report is presented. Given the instabilities documented at L3-4 and L5-S1, the L4-5 level would be incorporated into fusion mass. He subsequently notes that the pain generators have been well treated. All physical medicine and medical therapy interventions are completed. He notes that the requesting provider in face of multiple previous plain film studies none of which have identified reported instability should have sent these films out for independent assessment to objectify his notion. It is noted MRI does demonstrate disc pathology; however, this is more than two levels and should not be basis for any future. He notes there is no data to suggest that a 3 level fusion procedure would have any efficacy whatsoever. He subsequently non-certified the request.

The record contains request for ACDF at C4-5 and C5-6 with utilization review determination dated 02/10/12 and 01/30/12 in which the reviewers non-certify the request for ACDF at two levels.

The initial review regarding this request was performed by on 02/10/12. non-certified the request noting the request is for fusion of segments that do not demonstrate instability. ODG in general does not support fusion of more than 2 segments. He noted neurologic findings reported by are not found by other doctors examining the patient. He further noted the patient is 5'8" tall and weighs 252 lbs. He opines the claimant is at terrible risk for back

surgery secondary to infection and poor fusion rate. He subsequently non-certified the request.

A subsequent appeal request was reviewed on 02/22/12 by non-certified the request noting ODG does not allow a 3 level fusion. He notes the requestor has appealed based on recent x-rays done on 01/10/12 in which he feels demonstrates instability. However, the official reports demonstrate fixed retrolisthesis without instability at L4-5 level and only 3 mm of instability at L3-4. As such, he upholds the previous denial.

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

The request for inpatient L3-S1 revision laminectomy, discectomy, and fusion with instrumentation and implantable bone growth stimulator with 2 days inpatient stay is not supported as medically necessary. The submitted clinical records indicate the claimant has low back pain with radiation of lower extremities and has failed conservative treatment. The claimant has no quantifiable instability in lumbar spine. This has previously undergone utilization review twice and IRO which both determinations were upheld primarily for no evidence of instability. Most recently the case has been reviewed by two orthopedic spinal surgeons who have non-certified the request noting lack of instability at requested surgical levels. These reviews further note that ODG does not support multilevel fusion. Based on the totality of the clinical information, the previous denials are upheld, and medical necessity of the request is not established per ODG guidelines and non-certified.

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)