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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Oct/16/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar decompression/fusion L5/S1

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

Orthopedic spine surgery, practicing neurosurgery

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
Prior utilization review 09/11/09
Physical therapy notes 11/11/09-12/08/09
Hand written clinical notes 12/04/09-03/12/12
MRI lumbar spine 06/01/09
Clinical notes 07/30/09 and 09/04/09
Clinical notes 07/30/12-08/27/12
MRI lumbar spine 08/10/12
Prior reviews 08/20/12 and 09/14/12
Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who sustained an injury on xx/xx/xx due to a twisting motion. The claimant reported complaints of low back pain that became progressively worse. MRI studies from 06/09 revealed degenerative disc disease at L4-5 with a small 2-3mm central disc protrusion encroaching on the L5 nerve roots bilaterally. No significant canal or foraminal stenosis at L4-5 was noted. At L5-S1 there was degenerative disc disease with a disc protrusion centered to the left abutting the left S1 nerve root. The claimant was noted to be a smoker in 2009 at one pack per day. The claimant was seen on 07/30/12. The claimant is stated not to have improved. The claimant stated that she had not improved with physical therapy, chiropractic treatment, or use of anti-inflammatories. Physical examination revealed mild weakness on left ankle plantarflexion with loss of range of motion of the lumbar spine.

The claimant demonstrated antalgic gait and had difficulty heel and toe walking. Reflexes were decreased in the ankle bilaterally and straight leg raise was positive to the left. Radiographs were stated to show facet arthrosis and collapse of the disc space at L5-S1. Updated MRI studies were recommended and were performed on 08/10/12. The study revealed a midline disc protrusion at L5-S1 abutting but without displacement of the traversing S1 nerve roots. Clinical evaluation on 08/27/12 stated the claimant continued to have complaints of pain in the low back with weakness to the left leg. Physical examination was unchanged from the 07/12 exam. The claimant was recommended for a lumbar decompression and fusion at L5-S1. The request for lumbar decompression and fusion was denied by utilization review on 08/20/12 as there was limited clinical documentation regarding prior conservative treatment and no evidence of motion segment instability or severe disc space collapse. No psychological evaluation was provided for review. The request was again denied by utilization review on 09/14/12 as there was no evidence of spinal instability and no psychological screen.

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

The request for L5-S1 lumbar decompression and interbody fusion would not be recommended as medically necessary based on the clinical documentation provided for review and current evidence based guidelines. Claimant does have objective evidence consistent with lumbar radiculopathy to the left at S1. However, the clinical documentation does not establish significant motion segment instability or lateral recess stenosis that would reasonably require lumbar fusion at L5-S1. The MRI study reveals abutment of the S1 nerve roots with no evidence of significant disc space collapse or lateral recess stenosis. Additionally, no psychological evaluation was provided for review addressing possible confounding issues that would impact the claimant's post-operative recovery as outlined in current evidence based guidelines. As the clinical documentation provided for review does not meet guideline recommendations for the requested surgical intervention, medical necessity is not established.

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

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)