

# Applied Assessments LLC

An Independent Review Organization  
3005 South Lamar Blvd, Ste. D109 #410  
Austin, TX 78704  
Phone: (512) 772-1863  
Fax: (512) 857-1245  
Email: manager@applied-assessments.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Aug/27/2012

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar Laminectomy @ L5/S1, Spinal Cord Decompression, with possible Fusion

**A 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)

**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  
Cover sheet and working documents  
SOAP notes (mostly handwritten) and progress notes Dr. and Dr. 03/18/11-11/28/11  
CT lumbar spine without contrast dated 11/08/11  
Progress notes M.D. 12/15/11-08/02/12  
Radiographic report lumbar spine 3 views 01/23/12  
XR myelogram lumbar spine and CT lumbar spine with contrast 03/02/12  
Peer review report dated 04/19/12  
Utilization review determination dated 04/23/12  
Peer review report dated 05/11/12  
Utilization review determination dated 05/14/12  
Mental health assessment 06/26/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male whose date of injury is xx/xx/xx. The records indicate he fell off a rolling chair at work. The claimant complains of low back pain with numbness of the right hand and foot. He has history of previous L5-S1 fusion. Claimant remains symptomatic despite conservative care. CT myelogram performed 03/02/12 revealed post-operative changes, with limited evaluation of the L5-S1 space because of artifacts from bilateral transpedicular screws. No obvious significant discal herniation or foraminal stenosis was noted at this level or elsewhere. Mild anterolisthesis of L5 on S1 was noted with severe disc space narrowing at this level. It was noted that the L5 transpedicular screw extends slightly anteriorly and beyond the anterior margin of the vertebral body, but there is no significant obvious contact with the adjacent common iliac artery. The claimant is recommended to undergo lumbar laminectomy at L5-S1 with spinal cord decompression and possible fusion.

A request for lumbar laminectomy at L5-S1, spinal cord decompression with possible fusion was non-certified as medically necessary per peer review report dated 04/19/12 noting that

claimant had chronic low back pain. He had surgery with prior fusion. There is spondylolisthesis. This will be revision spine surgery. There was no psychological clearance to rule out psychological factors that may interfere with claimant recovery. This is prudent given this is revision lumbar fusion. As such the request is not medically necessary.

A reconsideration request was non-certified as medically necessary per peer review report dated 05/11/12. It was noted the submitted clinical records indicate that the claimant has a history of a prior L5-S1 fusion with posterior instrumentation. The records provide no data to establish that the claimant is unstable at this motion segment. CT myelogram does not identify significant filling defects. While it is noted that there is a 9.6mm anterolisthesis of L5-S1, there is no evidence that this is unstable. It is also noted that there is disc space narrowing, but again there is no evidence of significant stenosis, significant central canal or neural foraminal stenosis to establish the medical necessity for surgical intervention. The most recent clinical record does not provide a detailed physical examination establishing the presence of a progressive neurologic compromise. Further the record does not include a pre-operative psychiatric evaluation. In the absence of more detailed clinical information to establish the presence of instability or significant motion segment collapse and noting the lack of a pre-operative psychiatric evaluation the request cannot be certified as medically necessary at this time.

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

Based on the clinical information provided, the request for lumbar laminectomy at L5-S1, spinal cord decompression with possible fusion is supported as medically necessary. The claimant sustained an injury when he fell off a rolling chair on xx/xx/xx. He has a history of L5-S1 fusion with posterior instrumentation. The claimant has failed to improve despite conservative care. CT myelogram revealed post-operative changes, with limited evaluation of the L5-S1 space because of artifacts from bilateral transpedicular screws. No obvious significant discal herniation or foraminal stenosis was noted at this level or elsewhere. Mild anterolisthesis of L5 on S1 was noted with severe disc space narrowing at this level. It was noted that the L5 transpedicular screw extends slightly anteriorly and beyond the anterior margin of the vertebral body, but there is no significant obvious contact with the adjacent common iliac artery. A mental health assessment dated 06/26/12 cleared the claimant for surgery from a psychological perspective. Noting the objective findings on imaging studies with severe narrowing of disc space at L5-S1 with 9.6mm anterolisthesis, the proposed surgical procedure is supported 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)