

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

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

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

lumbar laminectomy, discectomy, spinal cord decompression and fusion with instrumentation at L5-S1

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

M.D., Board Certified Neurological 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that medical necessity is not established for the lumbar laminectomy, discectomy, spinal cord decompression and fusion with instrumentation at L5-S1.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Neurologic testing dated 03/31/10
Office visit notes dated 03/18/11-07/27/12
Operative report dated 06/01/11
Physical therapy progress notes 07/11/11-07/25/11
MRI lumbosacral spine 02/23/12
X-rays lumbar spine bending and flexion / extension 02/23/12
MRI thoracic spine 02/23/12
Office note 03/13/12
Utilization review determination dated 06/05/12
Utilization review determination dated 08/06/12

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a male whose date of injury is. He has low back pain radiating to the right lower extremity. MRI of the lumbar spine from 02/17/10 shows a large right paracentral posterior disc herniation 8mm effacing the S1 nerve roots. EMG on 03/31/10 reported findings consistent with right S1 radiculopathy. On 06/17/11 the claimant underwent lumbar laminectomy at L4-5, L5-S1. He participated in post-operative physical therapy. Initially he did quite well, but later reported recurrent back pain and right leg pain. Repeat MRI of the lumbar spine dated 02/23/12 revealed a large L5-S1 right paracentral disc herniation measuring 7mm effacing the S1 nerve root; L4-5 minor disc bulge. On examination it was noted the claimant complained of increased pain on the right leg as well as numbness above legs. He complained of severe right leg pain with increased sensory loss and right foot drop per evaluation on 05/18/12.

A request for lumbar laminectomy/discectomy/spinal cord decompression and fusion with instrumentation at L5-S1 was denied by physician advisor/pre-authorization review on 06/05/12 noting the medical report failed to objectively document exhaustion and failure of

conservative treatment such as activity modification, home exercise training, oral pharmacotherapy and physical therapy. Furthermore radiologic evidence of spinal instability as shown by x-rays was not provided. The radiologist's analysis of the MRI was not submitted for review. A detailed and complete physical examination was not provided. The claimant was examined on 06/27/12. Neurologically the claimant was still dragging his leg when walking, has constant right leg pain, with constant tenderness to the lumbar spine, has foot drop, sensation decreased on the L5-S1 dermatome, with decreased ankle jerk and straight leg raise is 45 degrees on the right leg and 80 degrees bilaterally.

A reconsideration request lumbar laminectomy/discectomy/spinal cord decompression and fusion with instrumentation at L5-S1 was reviewed on 08/06/12. It was noted there is now documentation of imaging findings including the 02/23/12 MRI identifying a large L5-S1 right paracentral disc herniation measuring 7mm effacing the S1 nerve roots, L4-5 minor disc bulge, and L5-S1 disc space narrowing suggesting associated disc pathology. It was noted per 05/18/12 medical report the claimant complains of low back pain and is status post L4-5, L5-S1 laminectomy on 06/17/11. Physical examination revealed sensory loss and right foot drop. The reviewer found that there were insufficient findings to confirm the presence of radiculopathy and associated clinical findings, including loss of relevant reflexes, muscle weakness and/or atrophy of appropriate muscle groups, and/or loss of sensation in the corresponding dermatomes. In addition, despite documentation of conservative treatment, there remained no clear documentation of exhaustion and failure of conservative treatment (activity modification, home exercise training, oral pharmacotherapy, and physical therapy). It was noted regarding the fusion there remains no clear documentation of a condition/diagnosis for which fusion is indicated such as instability or a statement that decompression will create surgically induced instability.

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

The claimant sustained an injury to his low back on xx/xx/xx. He had lumbar laminectomy at L4-5, L5-S1 on 06/17/11. He continued with back pain and right leg pain and weakness. Post-operative MRI dated 02/23/12 revealed a large L5-S1 right paracentral disc herniation measuring 7mm, and effacing the S1 nerve roots. A minor disc bulge also was noted at L4-5. As noted on previous reviews, there is no documentation that the claimant has exhausted conservative treatment. There is no evidence of motion segment instability at any level of the lumbar spine as demonstrated on flexion extension films that would support the need for instrumented fusion. Also no pre-surgical psychological evaluation addressing confounding issues was documented. For these reasons, it is the opinion of the reviewer that medical necessity is not established for the lumbar laminectomy, discectomy, spinal cord decompression and fusion with instrumentation at L5-S1.

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)