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Notice of Independent Review Decision

Date notice sent to all parties: 5/22/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4-s1 360 fusion with left laminectomy with a 3-day length-of-stay CPT 22558, 22585, 22612, 22614, 22842, 22845, 22851 (x2), 63047, 63048 (x2), 20930 (x4), 38220, arthrodesis, anterior interbody technique including minimal discectomy to prepare interspace (other than for decompression); lumbar dates of service from 4/16/2013 to 4/19/2013

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

Texas Licensed, Board Certified Orthopedic Surgeon

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 of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. 5/13/13 vendor letter
2. 4/29/13 and 4/18/13 denial letters
3. 7/17/12 notes
4. 4/25/13 letter
5. peer review
6. peer review

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant has been well documented to have sustained a twisting injury to his back. On the date of injury, the claimant was noted to have at the age of approximately xx persistent low back pain primarily with left lower extremity radiation. This is despite treatment with restricted activity, therapy, epidural steroid injections, a sympathetic block, multiple medications among other treatments. The claimant has in the past then felt to have had complex regional pain syndrome back in September 2012. Electrical studies on 06/21/2012 had revealed mild abnormalities of the left L5-S1 nerve roots. MRI had revealed severe degenerative changes on 05/11/2012. A CT myelogram more recently on 03/01/2013 has revealed marked disc space collapse at L5-S1 with disc herniations at L4-5 and L5-S1 with nerve root impingement of L5 and S1 primarily on the left side along with severe lateral recess stenosis at L4-5 and L5-S1. Denial letters had discussed the positive smoking history, complex regional pain syndrome, and the lack of the psychosocial screen along with lack of documented instability at L4-5.

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

The claimant in this reviewer's opinion has been recently well documented to have undergone a psychosocial screen, which has rendered a clearance for this individual as of 03/20/2013. The claimant does have evidence of such severe stenosis at the lateral recesses in particular of L4-5 and L5-S1. This combination of disc bony encroachment on the nerve roots would require extensive decompression that would result in destabilization of L4-5 and/or L5-S1 intraoperatively. The claimant does not have an issue with ongoing recently described complex regional pain syndrome. However, there is a valid concern regarding the up to one pack a day smoking history that was documented at least on or about 01/29/2013 and there has not been documentation of a definitive cessation of smoking or even plan for same. Therefore at this time, the claimant has not met guideline #6 for decompression fusion, which discusses in particular the need for complete cessation of smoking especially in a situation such as this in which there is a consideration for not just one, but two-level decompression and

expected fusion. Therefore at this time, exclusively based on that latter rationale of the smoking issues that are not resolved, the claimant does not have an indication for the multiple requested procedures as documented above

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- X 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
- X 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):