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Notice of Independent Review Decision

Date notice sent to all parties: 10/21/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient three days lumbar decompressions and laminectomy L1-2, L3 pedicle subtraction osteotomy, revision posterior spinal fusion T 10 – pelvis

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. Notice of IRO Assignment
2. LHL009
3. 9/11/13 and 10/3/13 Denial Letters
4. 10/9/13 Prospective IRO Response
5. 8/8/13 notes
6. 7/27/13 Assessment
7. 7/5/12-8/29/13 Follow-up Evaluations
8. 1/11/12 Lumbar Myelogram
9. 10/25/11 History and Physical
10. 3/6/06 Operative Report
11. 6/20/13, 9/6/13 and 9/26/13 28 TAC 134.600 for Preauthorization
12. 9/6/13 Faxed Precertification Request from Orthopaedic to Precertification Department
13. 9/11/13 Preauthorization Decision faxed
14. 10/2/13 Fax
15. 10/3/13 TML faxed
16. 5/13/13 Precertification Request
17. 3/6/06 Operative Report
18. 10/25/11 Notes
19. 1/11/12 Lumbar Myelogram
20. 7/5/12-8/29/13 Follow up Evaluations
21. 7/27/13 Assessment notes
22. 8/8/13 Tests and Notes

PATIENT CLINICAL HISTORY [SUMMARY]:

is said to have injured her lower back while working on xx/xx/xx. Subsequent to this she underwent extensive lumbar surgery and the implantation and removal of a spinal cord stimulator. She appears to have obtained little symptomatic of functional improvement as a result of treatment to date. When seen on 10/25/11, a pain management specialist, it was noted, "The patient has been on many strong narcotics". These records document persistent complaints of lower back pain and inconsistent radicular complaints. These records do not document any consistent abnormal neurological findings. A report of a lumbar myelogram and post myelographic CT scan done on 1/11/12 describes only "mild smooth medial displacement of the L3 and L4 root sleeves without decreased filling or cut off" and describes no evidence of nerve root compromise to explain the electrodiagnostic findings on 8/8/13. There is furthermore no description in these records of any diagnostic findings suggestive of segmental instability. I find in these records no support for the diagnosis of radiculopathy and believe that the patient's condition is related to mechanical back pain rather than any type of neurological condition.

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

The surgery that has been proposed essentially includes that of nerve root decompression, a spinal osteotomy and extension of a previous fusion. ODG indicates that the indication for decompressive surgery is that of radiculopathy. That diagnosis requires consistent radicular complaints, objective findings of examination and imaging studies that clearly demonstrate nerve root compression. None of these criteria have been met.

ODG indicates under Patient Selection Criteria for Lumbar Spinal Fusion the following possible indications that might apply to Ms. condition:

Segmental Instability (objectively demonstrable)

Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence.

Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature.

I do not believe that any of these criteria for fusion have been met. There is no evidence of segmental instability. While the patient likely has a primary diagnosis of mechanical back pain she has been effectively disabled for eight years and is heavily depended on narcotic pain medications. By any reasonable criteria she is an extremely poor candidate for a fusion for the diagnosis of mechanical back pain. Given the extent of the patient's previous surgery and her long-term disability, I see no basis to believe that any functional gains might be reasonably expected from the proposed surgery.

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
- 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)