Becket Systems

An Independent Review Organization
815-A Brazos St #499
Austin, TX 78701
Phone: (512) 553-0360
Fax: (207) 470-1075
Email: manager@becketsystems.com

AMENDED NOTICE OF INDEPENDENT REVIEW DECISION

Date notice sent to all parties: Dec/17/2012

Date amendment sent to all parties: Dec/27/2012

DATE NOTICE SENT TO ALL PARTIES: Dec/17/2012

DATE AMENDMENT SENT TO ALL PARTIES: Dec/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: L4-5-S1 Laminectomy, discectomy, fusion with instrumentation, implantable bone growth stimulator, L3-4 decompression, discectomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D**.** Board Certified Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] 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 the request for L4-5-S1 Laminectomy, discectomy, fusion with instrumentation, implantable bone growth stimulator, L3-4 decompression, discectomy cannot be supported as medically necessary per the Official Disability Guidelines.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO 11/21/12
Request for confirmation of receipt of request for IRO 11/21/12
Utilization review determination 11/12/12
Utilization review determination 11/19/12
MRI lumbar spine 11/30/10
Clinical notes Dr. 12/07/10-10/02/12
EMG/NCV 02/25/11
Psychiatric evaluation 01/13/12
Treatment records Injury and Pain Clinic various dates

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a male who was reported to have a date of injury of xx/xx/xx. On the date of injury, he was reported to have been pulling a table

dolly when the wheel got caught and his right foot caused him to fall backwards on to the carpeted floor. Records indicated that the claimant previously had physical therapy times 12 and EMG/NCV studies and right L4 and L5 transforaminal epidural steroid injections times two and right shoulder arthroscopy with rotator cuff repair and subacromial decompression and debridement and post-operative physical therapy and work conditioning and he was noted to be status post or he was noted to be recommended to undergo ACDF from C4 through C7 which was denied.

The record included an MRI of the lumbar spine which was dated xx/xx/xx. This study noted a posterior disc bulge extending laterally at L4-5. Posterior and central and paracentral disc bulge at L5-S1 and there was a posterior disc bulge extending laterally at L3-4 mildly asymmetric to the left and a posterior disc bulge at L2-3 and the claimant subsequently came under the care of Dr. and he was noted to have complaints of low back pain with bilateral leg pain and Dr. reported that flexion extension views were reported to indicate spinal functional spinal unit collapse and he opined that the L5-S1 segment is unstable and physical examination was reported to show evidence of discogenic pain and disc disruption at L3-4 and L4-5 and L5-S1 with clinical instability at L5 as well and EMG/NCV indicated a mildly active right L5 radiculopathy and it should be noted that this study was performed by doctor of chiropractic. Records indicated that the claimant underwent additional conservative treatments and a psychiatric evaluation was performed on 01/13/12 and this report indicated moderate depression and anxiety and he was noted to be a fair to good risk for surgery.

The most recent clinical note was dated 10/02/12 and he was reported to have failed conservative management and continued to have low back pain with radiation to the lower extremities and Dr. interpreted the lumbar flexion extension radiographs and noted on examination a positive spring test and positive extensor lag, positive sciatic notch tenderness, right greater than left and positive flip test and positive Braggard on the right, hypoactive knee jerk and ankle jerk on the right. Absent posterior tibial tendon jerk bilaterally and paresthesias in the L5 and S1 distributions bilaterally and weakness of the gastroc soleus complex bilaterally and tibialis anterior and the claimant was subsequently recommended to undergo decompression discectomy at L3-4 and L4-5 and L5-S1 with instrumented arthrodesis and implanted bone growth stimulator.

The initial review was performed by Dr. on 11/12/12 and Dr. non-certified the request and he noted that the claimant was a diabetic with noted degenerative spinal changes at multiple levels. He noted that there was no translational instability. He reported at least three levels of disc degeneration. He noted that the claimant would not require many of the proposed CPT codes, even if one were considered and even if one were to consider a fusion surgeon medically necessary. He noted that Official Disability Guidelines would not support a fusion surgery as medically necessary and non-certified the request.

The appeal request was reviewed by Dr. on 11/19/12 and Dr. xxxx non-certified the request, noting that MRI studies showed disc herniation at multiple levels from L3 to S1 and he noted that radiographs were reported to show disc space collapse at L4-5 and L5-S1, however. No radiographic reports were provided for review. Dr. found the request was not certified as medically necessary given that no imaging studies of the lumbar spine were submitted and he further noted that there was only limited discussion regarding prior conservative treatments including physical therapy and medication management and he noted that no psychological evaluation was submitted as recommended under current evidence based guidelines.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The submitted records indicate that the claimant has a history of low back pain with radiation to the bilateral lower extremities. The claimant has undergone extensive course of conservative treatment without benefit. It is clear that the claimant has exhausted conservative treatment. However, he would not be a candidate for fusion as there is absolutely no evidence of instability on lumbar flexion and extension views and only limited imaging reports were submitted. Independent radiographs of the lumbar spine were not provided. It is further noted that the psychiatric evaluation is

dated and suggests that the claimant is only a fair candidate for surgical intervention. Therefore, in the absence of documented instability and noting evidence of moderate comorbid depression and anxiety, it is the opinion of the reviewer that the request for L4-5-S1 Laminectomy, discectomy, fusion with instrumentation, implantable bone growth stimulator, L3-4 decompression, discectomy cannot be supported as medically necessary per the Official Disability Guidelines.

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

[X] 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)