



IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

DATE OF REVIEW: 11/15/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: RECONSIDERATION: Deny inpatient one to two days for lumbar anterior fusion L5-S1 at Cornerstone Regional Hospital as requested by Dr. Alejandro Betancourt.

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

Texas Board Certified Neurosurgeon

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 11/20/08 - Clinical Note - Unspecified Provider
2. 02/02/09 - MRI Lumbar
3. 02/04/09 - MRI Left Shoulder
4. 09/10/09 - Clinical Note - Unspecified Provider
5. 09/24/09 - Clinical Note - Unspecified Provider
6. 10/06/09 - Clinical Note - MD
7. 12/03/09 - Electrodiagnostic Study
8. 12/17/09 - MRI Lumbar Spine
9. 12/23/09 - Clinical Note - MD
10. 01/07/10 - Clinical Note - MD
11. 01/20/10 - Clinical Note - MD
12. 06/09/10 - Clinical Note - MD
13. 09/14/10 - Designated Doctor Evaluation
14. 10/05/10 - Clinical Note - MD

15.10/08/10 - Utilization Review
16.10/15/10 - Utilization Review
17.10/22/10 - Utilization Review
18. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury on xx/xx/xx when he slipped and fell while climbing shelves, landing on his left shoulder and lower back.

An MRI of the lumbar spine performed 02/02/09 demonstrated a central posterior protrusion-subligamentous disc herniation at L5-S1 measuring 4-4.7 mm in diameter, almost reaching the thecal sac. There was straightening of the lumbar lordotic curve due to muscle spasm.

An MRI of the left shoulder performed 02/04/09 demonstrated bursitis-synovitis in the subcoracoid-subscapularis bursa. There was no evidence of rotator cuff tear or labral tear.

The employee saw Dr. on 10/06/09. Physical examination revealed radicular pain from straight leg raise. There was good motor strength in the extremities. The employee was recommended for anterior lumbar interbody fusion.

Electrodiagnostic studies performed 12/03/09 were normal with no electrophysiologic evidence of a generalized sensory or motor polyneuropathy.

An MRI of the lumbar spine performed 12/17/09 demonstrated a central disc protrusion at L5-S1 measuring 4 mm, almost reaching to the thecal sac.

The employee saw Dr. on 01/07/10 with complaints of severe low back pain. The employee stated the pain runs down the left leg in a sciatic distribution. The note stated the employee was unable to stand for more than fifteen minutes. Physical examination revealed mildly positive straight leg raise on the left side. Sensation was intact. The employee was assessed with herniated nucleus pulposus at L5-S1. The employee was recommended for surgical intervention.

The employee saw Dr. on 01/20/10. The note stated the employee had failed conservative therapy and requires an anterior cervical discectomy and fusion. The note stated the employee had axial pain that was produced by the ruptured disc and by the instability of the segment.

The employee saw Dr. on 06/09/10 with complaints of back pain, as well as pain and numbness in the right leg. Physical examination revealed good motor strength of the upper and lower extremities. The employee was referred for chronic pain management.

The employee was seen for Designated Doctor Evaluation on 09/14/10. The employee complained of pain in the neck, low back, left arm, left shoulder, left hand, bilateral hips,

right knee, and right leg. The employee rated the pain at 5 out of 10 on the visual analog scale. Prior treatment includes six weeks of physical therapy and six weeks of chiropractic treatment without improvement. The employee was also status post arthroscopic resection and suprascapular decompression on 03/30/10. Current medications included Hydrocodone and ibuprofen. Physical examination revealed the employee ambulated with an antalgic gait. There was tenderness to palpation at L4-S1 centrally. Straight leg raise was to 90 degrees bilaterally. Lumbar range of motion was decreased with full effort. There was tenderness to palpation over the anterior aspect of the left shoulder. Deep tendon reflexes were normal. The employee was able to heel and toe walk with difficulty. The employee was assessed with internal derangement of the left shoulder, herniated nucleus pulposus of L5-S1, and right L5 radiculopathy. The employee was not placed at Maximum Medical Improvement (MMI) at that time.

The request for inpatient one to two days for lumbar anterior fusion L5-S1 at Cornerstone Regional Hospital as requested by Dr. was denied by utilization review on 10/08/10 due to no evidence of segmental instability.

The request for inpatient one to two days for lumbar anterior fusion L5-S1 at Hospital as requested by Dr. was denied by utilization review on 10/15/10 due to lack of evidence of lumbar instability. The employee was also a pack a day smoker. There was also no documentation of a psychosocial evaluation.

The request for inpatient one to two days for lumbar anterior fusion L5-S1 at Hospital as requested by Dr. was denied by utilization review on 10/22/10 due to no evidence of instability. Also, there was no documentation of a psychosocial evaluation.

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

The employee imaging studies reveal a disc herniation at L5-S1. There is no evidence of significant spondylosis, spondylolisthesis, or motion segment instability that would require the requested lumbar fusion with a 1-2 day inpatient stay. The employee has not undergone a psychological evaluation to date as recommended by current evidence based guidelines. Additionally, the employee is noted to have a 1 pack per day smoking habit which places the him at a higher risk for non-union. Given the lack of evidence regarding significant instability or severe degenerative collapse of the L5-S1 segment, no psychological evaluation, and the employee's continuing smoking habit; the procedure would not be indicated based on current evidence based guidelines.

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

Official Disability Guidelines, Online Version, Low Back Chapter