

SENT VIA EMAIL OR FAX ON
Aug/02/2011

Applied Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/01/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Laminectomy L4/5 instrumentation and fusion L4/5 possible L5 Iliac

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

M.D., Board Certified Orthopedic Surgery, Practicing Neurosurgery

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

1. Notification of adverse determination 05/10/11 regarding non-certification redo lumbar laminectomy L4-5, instrumentation and fusion L4-5, possible L5 iliac
2. Notification of reconsideration determination 06/29/11 regarding non-certification appeal redo lumbar laminectomy L4-5, instrumentation and fusion L4-5, possible L5 iliac
3. Letter of medical necessity 05/26/11 appeal redo laminectomy and fusion
4. Office visit notes Dr. 03/02/11-06/01/11
5. MRI lumbar spine 01/03/96
6. AP and lateral lumbar spine 01/03/96
7. Thoracic spine AP and lateral 12/14/10
8. MRI lumbar spine 01/10/11
9. Lumbar spine series with flexion / extension views 01/26/11
10. History and physical Dr. 04/05/11
11. Operative report transforaminal epidural steroid injection 04/15/11
12. Follow-up note Dr. 05/03/11
13. Medical records / peer review Dr. 06/23/11
14. Handwritten letter (undated)

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xx. Records indicate he fell

from a ladder. He complains of low back and right leg pain. The injured employee gives history of low back problems dating to 1996. The patient underwent lumbar laminectomy in 1996. MRI of lumbar spine dated 01/10/11 revealed disc extrusion with sequestered fragment in right side of central canal and right neural foramen at L4-5; small broad based disc protrusion L5-S1 with mild to moderate bilateral foraminal encroachment; findings suggestive of L5 spondylolysis, with no spondylolisthesis demonstrated. Radiographs of lumbar spine with flexion / extension views performed on 01/26/11 reported transitional lumbosacral vertebra with bilateral anomalous lumbosacral joints and spina bifida occulta; probable bilateral pars defects at L5 (spondylolysis), with no evidence of subluxation.

A request for redo lumbar laminectomy L4-5 with instrumentation and fusion L4-5 possible L5 iliac was reviewed on 05/10/11 and determined as non-certified as medically necessary. The reviewer noted that medical reports dated 03/02/11 and 04/05/11 reflected the injured employee complains of low back pain radiating to the right leg, with radiation of pain into right buttock thighs and toes, constant numbness of right leg. Physical examination revealed lumbar spine muscular spasm with restricted range of motion, tenderness on palpation of facet joints on right L4-S1, heel and toe walking abnormal, resisted isometric movements increased, sensory exam decreased on right L4-5 to touch and pinprick, straight leg raise positive on right at 35 degrees. MRI dated 01/10/11 revealed disc extrusion with sequestered fragment of right side of central canal and neural foramen at L4-5, small broad based disc protrusion L5-S1 with mild to moderate bilateral foraminal encroachment, suggestive of bilateral L5 spondylosis, no spondylolisthesis demonstrated. X-rays dated 01/26/11 revealed transitional lumbosacral vertebrae with bilateral anomalous lumbosacral joints and spina bifida occulta; probable bilateral pars defects at L5 (spondylolysis), with no evidence of subluxation. Conservative treatment includes medications and physical therapy. However, there is no documentation of associated clinical findings such as loss of relevant reflexes, muscle weakness and / or atrophy of appropriate muscle groups, failure of conservative treatment, and diagnosis / condition with supportive subjective / objective imaging studies for which fusion is indicated (such as instability). It was therefore determined that medical necessity of the request was not substantiated.

An appeal request was reviewed on 06/29/11 and the request for lumbar laminectomy L4-5, instrumentation and fusion L4-5 possible L5 iliac was recommended as non-certified as medically necessary. It was noted this was appeal request for redo lumbar laminectomy with instrumentation and fusion at L4-5 with possible L5 iliac bone graft and three day inpatient stay. It was noted the injured employee presents with increasing severity of pain radiating into right leg. During course of peer to peer discussion with requesting provider, it was noted that the requestor was unaware of guidelines for fusion. He stated the injured employee did not have flexion / extension views which showed instability. Furthermore, it was noted that the injured employee has not had psychological evaluation. There was no additional clinical information to substantiate the medical necessity of the requested service.

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

Based on the clinical information provided, medical necessity is not established for the proposed lumbar laminectomy L4-5, with instrumentation and fusion at L4-5 and possible L5 iliac crest bone graft. The injured employee fell from ladder on xx/xx/xx and sustained injury to low back. He had history previous lumbar laminectomy in 1996. MRI of the lumbar spine performed 01/10/11 revealed a disc extrusion with sequestered fragment in the right side of the central canal and right neural foramen at L4-5. There is a small broad based disc protrusion at L5-S1, with findings suggestive of bilateral L5 spondylolysis without spondylolisthesis. Flexion extension films revealed no evidence of motion segment instability. No pre-surgical psychological evaluation addressing confounding issues was provided. It appears that decompression on the right at L4-5 with removal of disc extrusion/ sequestered fragment may be appropriate; however, the criteria for fusion surgery have not been met.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL

BASIS USED TO MAKE THE DECISION

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES