

SENT VIA EMAIL OR FAX ON
Aug/24/2011

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Aug/24/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar L5/S1 Mini 360 with 3 day inpatient hospital stay

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

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. Request for IRO 08/04/11
2. Utilization review determination 07/11/11
3. Utilization review determination 07/21/11
4. Surgery scheduling checklist
5. Clinical records Dr. 03/10/11, 07/06/11
6. MRI lumbar spine 06/20/11
7. Psychiatric evaluation 01/10/11
8. MRI lumbar spine 01/07/11
9. MRI cervical spine 01/07/11
10. MRI thoracic spine 01/07/11
11. Radiographic report lumbar spine 12/21/10
12. CT lumbar spine 12/17/10
13. Lumbar and cervical myelogram 12/17/10
14. Clinical records Emmanuel brain and spine nerve surgery poorly reproduced and illegible

15. Hand written progress notes

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx who has complaints of low back pain radiating into the bilateral lower extremities. It's reported that on xx/xx/xx he sustained a fall and since that time he has had significant low back pain which is graded as 7/10 in severity with pain in the bilateral lower extremities. He denies any bowel control issues but has an occasional loss of urine with stress incontinence type symptoms. His pain is worse in his legs with walking and improves with rest. He's reported to have undergone a full course of physical therapy which only made his pain worse and multiple epidural steroid injections which have only provided temporary relief. He was seen by a neurosurgeon who recommended surgery however this was not approved due to documentation reasons. On 03/10/11 the claimant was seen by Dr. . He's 5'11" tall weighs 244 pounds he has a BMI of 34 he is in no apparent distress he's alert and oriented his mood and affect are normal. Motor testing was normal. He has normal reflexes throughout the bilateral upper extremities and bilateral lower extremities. He has decreased sensation in the L5 distribution and slightly in the S1 distribution right greater than left. There's a trace paresthesia. He's noted to have difficulty with toe walking bilaterally secondary to pain and weakness. He has reduced lumbar range of motion. He has significant tenderness to palpation of the paravertebral muscles. He has 5-/5 strength bilaterally in the EHL he has positive straight leg raise. MRI shows pars defects bilaterally at L5. There's an anterolisthesis of L5 on S1 which is grade 1. There's decreased disc height in evidence of mild spondylosis at L5-S1 as well there's retrolisthesis of L4 on L5 which is very mild. There's no significant spondylosis or disc derangement at L4-5. There's a small central disc bulge. MRI of the thoracic spine shows no significant disc pathology or neural compression. MRI of the cervical spine has significant artifact and shows only mild to minimal to mild spondylosis with no neural compression. The claimant is opined to be a good candidate for surgical intervention. He is recommended to undergo a 360 fusion at L5-S1. An MRI of the lumbar spine was performed on 06/20/11 which notes bilateral pars defects at L5 with minimal anterior subluxation of L5 on S1 with approximately 3mm. There are mild disc bulges at L4-5 and L5-S1 without significant central canal or neural foraminal stenosis. There is some narrowing of the right lateral to far lateral recess which may result in some compression of the nerve root. These findings are not significantly changed from prior examinations. The claimant was subsequently seen in follow up by Dr. on 07/06/11. He's noted to have continued low back pain and lower extremity pain. He's reported to have recently been discharged from the hospital and to have fallen as a result of his great toe not working properly especially on the right. He's now noted to have 4+/5 EHL weakness. He is again recommended to undergo a 360 degree fusion at L5-S1. On 07/11/11 Dr. reviewed the request and notes that the claimant has minimal subluxation at L5-S1 and that MRI documents pars defect bilaterally at L5 causing some instability and anterior subluxation of L5 on S1. He reports that without instability and without radiculopathy surgical treatment is not indicated. The subsequent appeal request was reviewed by Dr. who non-certifies the request noting that the claimant has undergone some conservative treatment measures that he has no gross instability or segmental instability documented that would support proceeding to a fusion of the spine at the L5-S1 level and therefore the request is non-certified.

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

The request for lumbar L5-S1 mini 360 with three day inpatient hospital stay is recommended as medically necessary and the previous denials are overturned. The submitted clinical records indicate that the claimant sustained an injury to his low back as a result of a fall from a truck. The records indicate that the claimant has undergone extensive conservative treatment without improvement. Radiographs of the lumbar spine show a grade 1 anterolisthesis of L5 on S1 with some movement on flexion extension views. The claimant is noted to have a bilateral pars defect at L5-S1 in order to appropriately address the claimant's pathology the performance of a decompression would clearly cause iatrogenic instability at the L5-S1 level. As such the performance of a fusion procedure would be clinically indicated. The records indicate that the claimant has undergone a pre-operative psychiatric evaluation and that there were no relative contraindications to the performance of surgery.

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

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

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES