

SENT VIA EMAIL OR FAX ON
Aug/26/2011

Applied Resolutions LLC

An Independent Review Organization
900 N. Walnut Creek Suite 100 PMB 290
Mansfield, TX 76063
Phone: (214) 329-9005
Fax: (512) 853-4329
Email: manager@applied-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/26/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Thoracotomy Discectomy T9/10; Fusion T9/10 with Rib Autograft

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

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. Cover sheet and working documents
2. MRI lumbar spine without contrast dated 06/21/10
3. Office visits Dr. dated 09/28/10-05/24/11
4. Letter to Dr. from M.D. dated 04/06/11
5. Notification of determination for request thoracotomy discectomy T9-10, fusion T9-10 with rib autograft dated 06/16/11
6. Notification of determination for appeal request thoracotomy discectomy T9-10, fusion T9-10 with rib autograft dated 08/02/11

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xx. The records indicate he was injured accident. The flipped over during the accident and the injured employee was thrown about in the. MRI scan of the thoracic spine revealed a 6mm central and left paracentral disc protrusion at T9-10 effacing the anterior aspect of the thecal sac and abutting the spinal cord.

On examination the injured employee had no evidence of motor or sensory deficits. Deep tendon reflexes were within normal limits. There was no evidence of upper motor neuron signs. The injured employee did have positive Valsalva maneuver, with worsening of symptoms with coughing, sneezing and straining. He was treated conservatively with physical therapy and epidural steroid injections without improvement. The injured employee was recommended to undergo surgical intervention with thoracotomy discectomy at T9-10 with fusion at T9-10 with rib autograft. Records indicate that the injured employee had designated doctor evaluation and the designated doctor determined the injured employee was not at maximum medical improvement and recommended surgical treatment. The injured employee also underwent second opinion consultation with Dr. who also opined that the injured employee required surgical intervention.

A utilization review notification of determination dated 06/16/11 non-certified a request for thoracotomy discectomy T9-10, with fusion T9-10 with rib autograft. The reviewer noted that documentation indicates the injured employee has a 6mm left paracentral disc protrusion at T9-10 indenting the spinal cord. He has been unresponsive to conservative care to date and remains symptomatic. It was noted there was a lack of positive imaging evidence to support the request for fusion procedure. There also was no psychosocial evaluation submitted for review in accordance with practice guidelines. The injured employee had no relief from prior injection and MRI did not reveal foraminal encroachment. As such it was determined the clinical documentation submitted for review did not support certification of the request at this time.

A utilization review determination dated 08/02/11 regarding reconsideration/appeal of thoracotomy discectomy T9-10, with fusion T9-10 with rib autograft was determined to be non-certified. The reviewer noted that the injured employee complains of pain in the lower thoracic spine radiating around the chest wall. On physical examination there was normal function of the lower extremities. There was increased tenderness in the thoracic area with no cervical compressibility. MRI of the thoracic spine dated 06/21/10 revealed a 6mm left paracentral disc protrusion at T9-10 indenting the spinal cord. Records indicate the injured employee has had physical therapy to address pain in the lower thoracic spine, but there were no clinical records submitted to validate that the injured employee underwent an appropriate sufficient course of physical therapy. Response of the injured employee to mentioned epidural steroid injection was not objective documented. It was also noted the records do not indicate a pre-operative psychiatric evaluation has been performed indicating that the injured employee has realistic expectations for the procedure. It was further noted that x-rays of the thoracic spine showed normal results with no bony abnormality that warrants fusion at the level of T9-10 with rib autograft.

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

Based on the clinical data presented, medical necessity is established for thoracotomy discectomy T9-10, with fusion T9-10 with rib autograft. The injured employee sustained an injury. MRI of the thoracic spine on 06/21/10 revealed a 6mm central and left paracentral disc protrusion at T9-10 effacing the anterior aspect of the thecal sac and abutting the spinal cord. The injured employee had examination findings consistent with thoracic spine lesion with radiation of pain to the chest wall and increased symptoms with Valsalva maneuver. The injured employee's condition has been refractory to conservative treatment including physical therapy, medications, and epidural steroid injection. The injured employee was seen by Dr. for a second surgical opinion and based on his review of the imaging studies and clinical examination of the injured employee, Dr. concurred that surgical intervention was appropriate. Noting the surgical approach for removal of the extruded disc, fusion of the T9-10 level is appropriate and medically necessary.

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

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES