

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/03/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4-L5 TLIF with posterior spinal instrumentation, lateral arthrodesis, nerve root decompression, CPT Codes 22612, 22842, 22630, 22899, and 38220 with a 3-day inpatient length of stay

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

M.D., board certified in 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

Adverse Determination Letters, 2/18/09, 3/6/09

ODG Guidelines and Treatment Guidelines

MD, 2/12/09, 3/16/09, 3/5/09, 3/6/09, 2/5/09, 1/8/09, 12/9/08, 10/6/08, 8/18/08, 9/22/08, 7/22/08, 6/26/08, 2/11/08, 1/8/08, 1/17/08, 12/10/07, 11/12/07, 10/4/07, 9/20/07, 9/25/06, 12/4/06, 1/4/07, 2/8/07,

MRI of Lumbar Spine, 10/1/07, 10/1/08

Lumbar Myelogram, 1/3/09

Post Myelogram CT Lumbar Spine, 1/30/09

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who, according to the records, has undergone a previous L4/L5 laminectomy in the past and now comes in for ongoing back pain and some radiculopathy. The patient has undergone various studies and conservative care including physical therapy. In particular, a myelogram with post myelographic CT scan was performed and showed disc protrusions at L4/L5 and L5/S1 without significant canal narrowing, and some bilateral foraminal narrowing at L4/L5 secondary to the protrusion. An MRI scan was performed, which showed similar findings with no canal encroachment. There was noted prior surgery at L4/L5 with left laminectomy. There was noted to be some residual disc at this level associated with

an annular tear and some moderate foraminal stenosis along with moderate canal narrowing. The surgeon, however, in his medical records reports that there is “a very large recurrent left L4/L5 disc herniation.” However, this does not correspond to the findings that the radiologist has reported. The physician also notes there are some traction spurs for which he extrapolates that there is instability.

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

While traction spurs particularly in the postsurgical situation or part of a degenerative cascade are indicative of microinstability, they do not satisfy the criteria for the Official Disability Guidelines and Treatment Guidelines. Furthermore, while abnormal on MRI scan, this has not been found to be a specific pain generator. Additionally, the reviewer did not find evidence from the medical records that this patient has been psychologically profiled prior to any surgical intervention being entertained. It is for these reasons that this patient does not meet the Official Disability Guidelines and Treatment Guidelines criteria. The treating physician has not included within the medical records the specific reasons why the (state mandated) guidelines in this particular case should not be followed. The reviewer finds that medical necessity does not exist for L4-L5 TLIF with posterior spinal instrumentation, lateral arthrodesis, nerve root decompression, CPT Codes 22612, 22842, 22630, 22899, and 38220 with a 3-day inpatient length of stay.

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

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

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)