

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/17/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Posterior Lumbar Fusion with Pedicle Screws and Rods, ICBG (iliac crest bone graft) L2-L4
Stage 1: TLIF L2/3, L3/4 Stage 2: Bilateral Decompression L2-4, Hardware Removal L4-S1,
Spinal Instrumentation and Fusion L2-L4, LSO Brace, Bone growth stimulator, cryo unit, and
3 days inpatient 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

PATIENT CLINICAL HISTORY SUMMARY

This is a male with injuries to his low back on xx-xx-xx, according to the records. Apparently he was hit by an 18-wheeler tractor trailer at the time of an original accident and had a two-level lumbar fusion performed in 2004 on the L4/L5 and L5/S1 levels. He developed recurrent pain in his low back and left posterior thighs and radiating posterior thigh pain but no below the knee. He has a negative neurological examination as there is no discrete weakness noted, although he did have some L5 motor weakness on the left and some

decreased sensation at that level, which naturally would be causing the current L2/L3 and L3/L4 complaints but rather related to the previous levels that have already been addressed. Flexion/extension views and AP and lateral x-rays as well as CT scan show solid bony fusion at the L4/L5 and L5/S1 levels without instability. Hardware loosening was not noted. He complains of some calf numbness and foot numbness. He apparently has some diabetic polyneuropathy.

He has some dermatomal glove-and-stocking type sensory dysfunction in the lower extremities. There is said to be some decreased sensation in the anterior thigh on the left. His CT scan myelogram, which was performed in February 2009, shows a retrolisthesis at L2 and L3 with a 4-mm broad-based disc protrusion and facet arthrosis. There was some canal stenosis and foraminal stenosis at the L2 level and underfilling of the L3 roots bilaterally. There was note of a previous laminotomy at L3/L4, although the L4 roots were apparently normal. Once again, the fusion at L4/L5 and L5/S1 was found to be solid. He is reported to have moderate depression and severe anxiety, attributed to his injured worker status. Current request is for extension of the two-level fusion into a four-level fusion.

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

Based on the ODG Guidelines, this patient does not meet criteria of the statutory mandated guidelines for several reasons. Firstly, a four-level fusion is not entertained by the guidelines, and severe structure instability or progressive neurologic dysfunction such as associated with spinal fractures and dislocations, spondylolisthesis, and neurologic compromise are not present in this particular individual. The treating physician has not explained why the ODG Guidelines, which are mandated to guide the IRO in its review, should be set aside. Four-level fusion is not entertained as being an acceptable procedure by the guidelines, especially when envisioned in the absence of documented instability. It is for this reason, i.e. that the medical records do not contain the information necessary to explain why the ODG Guidelines should be set aside, that this reviewer is unable to overturn the previous adverse determination. The reviewer finds that medical necessity does not exist for Posterior Lumbar Fusion with Pedicle Screws and Rods, ICBG (iliac crest bone graft) L2-L4 Stage 1: TLIF L2/3, L3/4 Stage 2: Bilateral Decompression L2-4, Hardware Removal L4-S1, Spinal Instrumentation and Fusion L2-L4, LSO Brace, Bone growth stimulator, cryo unit, and 3 days inpatient 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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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