

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/12/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XLIF L3-4 to include CPT 63090, 22558, 22845, 20931, 95920

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

MD, Board Certified Orthopedic Surgeon
Spine surgeon

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

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 6/26/09, 7/6/09
Surgery Scheduling Slip/Checklist, 6/12/09
Back Institute, 6/18/09, 5/20/09, 6/17/09, 6/8/09
Lumbar Myelogram, 4/28/09
CT Post Mylo/Disco-Lum Spine, 4/28/09
Lumbar Spine, 3 Views, 5/20/09
MD, 4/9/09
Previous Treatment, undated
MD, 3/31/08

PATIENT CLINICAL HISTORY SUMMARY

This is a male who has undergone a three-level lumbar fusion in 2006. Subsequent studies have shown severe stenosis of the L2/L3 level above the previous fusion. There has been various discussions concerning this in the medical records. The radiologist has not mentioned pseudoarthrosis, but the treating surgeon notes a halo effect around the L3 screws and recommends an extreme lateral interbody fusion for this case.

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

The current request is for extreme lateral interbody fusion, which is a minimally invasive

procedure. The procedure codes include vertebral corpectomy, transperitoneal approach, with decompression of the spinal cord. The medical records do not indicate that there has been any attempt to identify this presumed L3/L4 pseudoarthrosis as a pain generator. The literature is replete with evidence that a majority of pseudoarthrosis are not symptomatic. Hence, this reviewer has no alternative but to uphold the previous adverse determination, as the pain generator has not been identified, and the surgical procedures requested seem inconsistent with the surgical approach. The request does not meet ODG guidelines. The reviewer finds that medical necessity does not exist for XLIF L3-4 to include CPT 63090, 22558, 22845, 20931, 95920.

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)