

# Core 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/17/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation and implantation of bone growth stimulator L4-5-S1 with 2 day LOS (22899, 63030, 63035, 69990, 62290, 22612, 22614, 22851, 20938, 22842, 22558, 22585, 20975, 63685, 22325, 99220)

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

M.D., Board Certified Orthopedic 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

MRI Lumbar Spine: 11/10/08

Dr. Office Records: 01/07/09

Notice of Disputed Issue and Refusal to Pay Benefits Letter: 01/12/09

Dr. – Pain Management Procedure Report: 01/20/09

Dr. Office Records: 01/27/09

Dr. Office Records: 02/10/09

Dr. – Peer Review: 02/12/09

Ph. D: 06/11/09

EMG/NCV studies: 06/18/09

Authorization Request for surgery: 07/02/09

Peer Review – Dr.: 07/08/09

Preauthorization Determination – Denied: 07/20/09

Authorization Request – Appeal denied requested surgical procedure: 07/24/09

Adverse Determination Letters, 7/20/09, 7/24/09

#### **PATIENT CLINICAL HISTORY SUMMARY**

This xx-year-old male sustained a lifting injury with a reported snapping pain in his lower back on xx/xx/xx. A lumbar MRI dated 11/10/08 reported moderate spondylosis changes L4 through S1 with disc protrusion/extrusion L4-5 and disc protrusion at L5-S1 and bilateral lateral recess stenosis at L4-5 due to disc protrusion/extrusion and facet hypertrophy. Documentation revealed subjective complaints of constant dull achy low back pain radiating into the right lower extremity with associated numbness and tingling as well as persistent and progressive right lower extremity weakness and giving way. A diagnosis of lumbar herniated nucleus pulposus with instability and right radiculopathy with muscle weakness at L4-5 and L5-S1 was recorded on 02/10/09. X-rays taken on 02/10/09 included pelvic films revealing no hip degenerative joint disease or sacroiliac joint sclerosis and lumbar x-rays including flexion and extension that revealed instability at L4-5 and L5-S1 with spondylosis, stenosis, facet subluxation and lateral recess stenosis. The 02/10/09 exam revealed positive findings including spring test at L4-5 and L5-S1, extension lag, left straight leg raise, bilateral flip test and right Lasègue test. The exam also revealed decreased Rt. knee and ankle jerks with right lower extremity motor weakness and paresthesias.

The 06/11/09 documentation revealed the claimant completed 5 sessions of individual psychotherapy sessions for a diagnosis of reactive depression and anxiety, which was currently in the moderate range and was now noted to be coping well enough to proceed successfully with the suggested surgery. EMG/NCV studies completed on 06/18/09 revealed evidence of right lumbar radiculopathy at the right L5 nerve root with suggestive right S1 nerve root involvement as well. Failed conservative measures included medications, physical therapy and epidural steroid injection. Dr. requested authorization to proceed with a lumbar laminectomy, discectomy arthrodesis with cages, posterior instrumentation and implantation of a bone growth stimulator at L4-5 through L5-S1 with a 2-day inpatient length of stay.

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

The requested L4 through S1 lumbar decompression and fusion is not medically necessary based on review of this medical record.

While the claimant has degenerative disc disease of the lower lumbar spine with what appears to be disc herniations at L4-5 and L5-S1, it is not clear to this reviewer that the evaluation of Dr. actually describes structural instability. It is not clear to this reviewer what the extension angle of 16 degrees at L4-5 or the extension angle of 26 degrees at L5-S1 means. There is no discussion of a change between his flexion/extension appearance in terms of angulation nor in terms of translation.

ODG guidelines document the use of lumbar spine fusion in patients who have structural instability. Yet, Dr. has not clearly described the instability. Therefore, in light of the fact that the measurement system used by Dr. in reference to instability is unclear, and the records do not clearly document the difference between a flexion/extension angle and/or evidence of translation, then the requested surgical intervention is not medically necessary.

The reviewer finds that medical necessity does not exist for Lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation and implantation of bone growth stimulator L4-5-S1 with 2 day LOS (22899, 63030, 63035, 69990, 62290, 22612, 22614, 22851, 20938, 22842, 22558, 22585, 20975, 63685, 22325, 99220).

ODG Indications for Surgery -- Discectomy/laminectomy :

- Radiculopathy, weakness/atrophy, pain
- EMG optional, Imaging for correlation with radicular findings.
- Diagnostic imaging modalities requiring ONE of the following: MRI, CT scan, Myelography/CT myelography & X-Ra
- Conservative Measures -- Activity modification of 2 months & at least one of the following;

\*\* NSAIDs, analgesic, muscle relaxants, ESI

- Must have one of the following: PT, Chiro. Psychological screening, back school.

Spinal Fusion --- Pre-Operative Surgical Indications Recommended:      should include all of the following:

- 1) All pain generators are identified and treated; &
- 2) All physical medicine and manual therapy interventions are completed; &
- 3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography & MRI demonstrating disc pathology; &
- 4) Spine pathology limited to two levels;
- 5) Psychosocial screen with confounding issues addressed
- 6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing.

**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)