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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/11/2009

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Lumbar laminectomy w/fusion and instrumentation L3-4 and L4-5 with 1 night LOS and TLSO brace

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

MRI Lumbar Spine, 06/13/00
Office note, Dr., 06/19/00, 09/07/00, 09/20/00, 10/29/00, 07/23/07, 02/05/08, 03/31/08, 06/15/08, 06/15/09, 08/06/09, 10/05/09, 10/09
Lumbar myelogram/Post CT scan, 08/22/00
Post Myelogram CT scan, 08/22/00
Cervical Myelogram/Post CT: 08/22/00; 03/25/08
Cervical Spine X-Rays: 07/23/07; 05/04/09; 08/06/09
Operative Report – myelogram : 03/25/08
MRI Cervical Spine: 06/09/09
Operative Report – cervical surgery: 07/01/09
Discharge Summary: 07/02/09
Lumbar Spine X-Rays, 07/23/07
Lumbar Myelogram, 03/25/08
Post Myelogram CT scan, 03/25/08
MRI Lumbar Spine, 06/09/09
Peer Review – Dr., 10/14/09
Appeal -- Authorization Request, 10/21/09
Peer Review -- Dr., 10/26/09
Peer Review, 10/28/09
Official Disability Guidelines 2010 Low Back

PATIENT CLINICAL HISTORY SUMMARY

This male sustained injuries to his neck and low back on xx/xx/xx when a chain broke

causing him to fall off a truck bed. Records listed a diagnosis of severe cervical and lumbar disc disease with mechanical pain and radiculopathies. The claimant had a prior history of a gunshot wound to the abdomen in 1979 with radiographic evidence of a retained bullet fragment at the L3-4 level. Records revealed the claimant had severe low back and bilateral hip and lower extremity pain with associated numbness, dysesthesias and weakness. Dr. documented findings from the 03/25/08 lumbar myelogram and post CT scan that included severe post-traumatic disc pathology at L3-4 and L4-5 with stenosis and root compression. Completion of care including conservative management and surgical intervention was delayed over the years due to the claimant's repeated incarcerations. The claimant underwent cervical fusion in July 2009.

A recent lumbar MRI completed on 06/09/09 revealed fairly severe multilevel degenerative disc disease (DDD) and spondylosis most notable at L3-4 and L4-5 with nonspecific areas of endplate enhancement due to DDD and enhancement along the posterior disc margin at L4-5, which may represent an annular tear and/or possible underlying disc herniation. The 10/05/09 office record noted severe L3-4 and L4-5 post-traumatic disc pathology with stenosis, herniated disc and root compression with chronic mechanical low back disorder and bilateral foraminal narrowing at L5-S1 that required Hydrocodone and Flexeril. No other objective findings or conservative care was provided in the reviewed records. Authorization was requested for a lumbar laminectomy with fusion and instrumentation at L3-4 and L4-5 with one night length of stay and a thoracolumbosacral orthosis brace.

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

The available records do not contain any recent neurologic findings. The studies outline some age related degenerative findings. There is no specific instability. It is unclear from the records what recent conservative care has been provided to the patient. In addition, the available records do not contain a psychological screening. There is no comment on smoking history and whether or not if a smoker, the claimant has been counseled against the same. The records in this case do not satisfy ODG criteria for the requested procedure. The reviewer finds that medical necessity does not exist at this time for lumbar laminectomy w/fusion and instrumentation L3-4 and L4-5 with 1 night LOS and TLSO brace.

Official Disability Guidelines 2010 Low Back

Spinal Fusion:

Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction.

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.

ODG guidelines for Back Brace Postop Fusion:

- o Under study -- a standard brace would be preferred over a custom post-op brace
- o There is no scientific information on the benefit of bracing for improving fusion rates or clinical outcomes following instrumented lumbar fusion for degenerative disease.

Milliman Care Guidelines 13th Edition Surgery and 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)