

# Core 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/16/2009

**IRO CASE #:**

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

Redo L5/S1 lami and TLIF inpatient stay x 1 day (63042, 63044, 22842, 22612, 22614, 22630, 22632, 22851, 20936, 20930, 38220)

**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**

Office note, Dr. , 11/17/05

Flexion extension views, 11/07/06

Office notes, Dr. , 11/7/07, 01/30/07, 02/27/07, 06/09/09, 08/11/09

Dr. , PA-C, 12/21/06, 01/10/07

Operative note, Dr. , 01/10/07

Lumbar spine X-ray, 06/23/09

EMG, 06/23/09

Office note, Dr. , 08/13/09

ODG Guidelines and Treatment Guidelines

Adverse Determination Letters, 8/25/09, 8/17/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male who is status post an L5-S1 laminectomy and discectomy performed on 01/10/07. The claimant was returned to light duty on 02/27/07. Dr. evaluated the claimant on 06/09/09 for a one-year history of left lower extremity radicular pain. The diagnoses were thoracic or lumbar radiculitis and small right L5-S1 herniated disc. There was no weakness on examination. Dr. recommended pain management, electromyography and x-rays. The 06/23/09 lumbar spine x-rays including flexion and extension showed mild degenerative

spondylosis at the lumbosacral junction and no evidence for ligamentous instability. The 06/23/09 electromyography showed left L5-S1 radiculopathy, mild generalized sensory/motor peripheral neuropathy most consistent with diabetes mellitus. Dr. evaluated the claimant on 08/11/09. Dr. reviewed the electromyography and MRI. Dr. stated that the MRI showed a broad based central disc bulge with significant endplate changes. Physical examination was "none recorded". Dr. recommended a redo L5-S1 laminectomy and transforaminal lumbar interbody fusion.

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

No MRI report has been made available for review. Based on the treating physician's interpretation, it does not appear that a recurrent disc herniation has been identified. It does not appear that instability has been identified. Although the electrodiagnostics would suggest persistent radicular findings, it must also be noted that the claimant is diabetic and has evidence of diabetic peripheral neuropathy as well. The records provided for review do not establish medical necessity for the repeated decompression with fusion at the L5-S1 level. The reviewer finds that medical necessity does not exist at this time for Redo L5/S1 lami and TLIF inpatient stay x 1 day (63042, 63044, 22842, 22612, 22614, 22630, 22632, 22851, 20936, 20930, 38220).

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, chapter low back-Fusion

Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery -- Discectomy.

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion 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 (see discography criteria) & 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. (Colorado, 2001) (BlueCross BlueShield, 2002)

Milliman Care Guidelines, Inpatient Surgery, 13th Edition

**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)