

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/01/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient LOS x 2 days, Revision Lumbar Surgery, 63042, Lateral Arthrodesis of Pedicle Screw Holes 22612, Exploration of Arthrodesis 22830, Bone Graft 20938 (possible), Removal of PLSF L4-5-S1 22852

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

Adverse Determination Letters, 8/10/09, 7/29/09

ODG Guidelines and Treatment Guidelines

Expected Surgery Codes

, MD, 7/21/09, 7/20/09, 6/16/09, 3/10/09

Lumbar Myelogram, 7/14/09

Post Myelogram CT of the Lumbar Spine, 7/14/09

, MD, 6/9/08, 3/27/08, 12/11/07, 11/14/07, 9/17/07, 8/22/07, 5/30/07, 2/22/06, 3/2/06,

CT Scan of the Lumbar Spine without contrast, 9/10/07

MRI Lumbar Spine, 1/10/06

EMG and Nerve Conduction Study, 2/14/06

, MD, 4/20/06, 9/15/06

, MD, 5/27/09, 3/25/09, 12/3/08, 10/6/08, 8/6/08, 6/9/08, 4/4/08, 1/31/08, 1/3/08, 11/28/07,

10/4/07, 9/5/07, 8/7/07, 6/20/07

, DO, 4/27/07

, PT Notes, 2/10/09, 12/23/08, 10/11/07, 8/1/07, 7/31/07, 7/25/07, 7/24/07, 7/23/07, 7/20/07,

7/19/08, 7/9/07, 7/3/07, 7/2/07, 6/27/07, 6/26/07, 6/22/07, 6/21/07, 6/4/07

PPE, 2/6/09, 12/16/08

Operative Report, 8/20/06

PATIENT CLINICAL HISTORY SUMMARY

This is a xx-year-old claimant injured on xx/xx/xx in a slip-and-fall on a wet floor. She had a small bulge and a small herniation at L5/S1 and subsequently underwent a two-level anterior and posterior fusion. She continued with lower extremity complaints. She has been noted by subsequent imaging studies to have a solid fusion at L4/L5 and L5/S1. Dr. noted worsening of symptoms and diagnosed pseudoarthrosis of the posterolateral fusion, notwithstanding solid anterior fusion. He also notes that the pedicle screws positions show bicortical fixation in the sacrum. He recommends hardware removal, exploration of the fusion, bone grafting and revision surgery.

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

Records submitted for this review show that this patient has a solid fusion, and in particular, the patient had a solid anterior interbody fusion. As per the ODG, posterior lateral fusion masses are not an indication for surgery, as they resolve over time. The presence of bicortical sacral fixation is the recommended technique to obtain the maximum fixation within sacrum, as lack of bicortical fixation predisposes the fusion to pseudoarthrosis and loosening. Given the imaging studies within the medical records, there is absolutely no indication clinically or medically that revision surgery is indicated. The request for this procedure does not conform to Official Disability Guidelines, which are statutorily mandated. The reviewer finds that medical necessity does not exist for Inpatient LOS x 2 days, Revision Lumbar Surgery, 63042, Lateral Arthrodesis of Pedicle Screw Holes 22612, Exploration of Arthrodesis 22830, Bone Graft 20938 (possible), Removal of PLSF L4-5-S1 22852.

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)