

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW:

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar ALIF at L5-S1 (63090, 22558, 22851, 20931, 95920 x 2 LOS x 1 day).

A 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)

The requested service, lumbar ALIF at L5-S1 (63090, 22558, 22851, 20931, 95920 x 2 LOS x 1 day), is medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 2/14/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 2/16/11.
3. Notice of Assignment of Independent Review Organization dated 2/16/11.
4. Medical Records from a D.O. dated 6/29/10 and 1/20/11.
5. Medical Records from a D.C. dated 5/17/10, 6/8/10, 8/3/10, 8/30/10, 9/27/10, 10/25/10, 12/20/10 and 1/17/10.
6. Medical Records from an M.D. dated 8/18/10, 9/15/10, 10/13/10, 12/8/10 and 1/5/11.
7. MRI report from an M.D., Ph.D. dated 5/6/10.
8. Medical Records from a D.O. dated 10/4/10 and 8/13/10.
9. Pre-Surgical Psychological Evaluation completed by a L.P.C. dated 7/21/10.
10. EMG & Nerve conduction studies conclusions completed by a D.O., Ph.D. dated 10/1/09.
11. MRI completed by an M.D. dated 9/4/09.
12. Letter from a D.C. dated 9/30/09.
13. Letter from an M.D. dated 10/7/09.
14. Letter from an M.D. dated 11/22/10.
15. Denial Documentation dated 9/24/10, 10/4/10, 10/26/10, 1/26/11 and 2/14/11.
16. ODG – TWC: Low Back –Lumbar & Thoracic (Acute & Chronic).

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work related injury to his lumbar spine on xx/xx/xx involving a rear end motor collision. The patient noted upper back pain, right upper extremity pain and numbness into the right upper extremity, neck pain, intermittent headaches, lower back pain and numbness into the left lower extremity. An MRI of the lumbar spine performed in September 2009 revealed central and paracentral bulge up to 4mm on the right with ligamentum flavum hypertrophy and mild facet arthropathy and mild to moderate left foraminal narrowing with mild right foraminal narrowing at L3-4 and a central and paracentral bulge up to 3 mm with a spinal canal patent at 1 cm, mild to moderate facet arthropathy, moderate left foraminal narrowing and mild to moderate right foraminal narrowing at L5-S1. X-rays performed in January 2011 showed instability with disc narrowing at L5-S1 with retrolisthesis about 4mm; slight disc space narrowing was seen at L3-4 as well. The provider noted disc space collapse at L5-S1 with neural foraminal stenosis and instability. Electromyography (EMG) studies demonstrated severe left peroneal mononeuropathy.

The patient has failed conservative treatment consisting of epidural steroid injections, chiropractic care, physical therapy and medication management. The patient's provider is requesting authorization for lumbar spinal fusion, specifically lumbar ALIF at L5-S1 (63090, 22558, 22851, 20931, 95920 x 2 LOS x 1 day). The URA indicates the requested service is not

medically necessary. Specifically, the URA states there is no therapy progress report pertaining to the lumbar region that objectively documents the clinical and functional response of the patient and failure of medication. The URA additionally states that the clinical information did not provide objective documentation of the patient's clinical and functional response from previous epidural steroid injections.

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

Review of the submitted clinical information indicates the patient meets Official Disability Guideline criteria for lumbar spine fusion. The patient's pain generator has been identified. A lumbar MRI revealed disc pathology. The patient's pathology is one level. There is evidence of retrolisthesis which is an acquired or degenerative spondylolisthesis (Vamvanji, et al). Spinal instability has been confirmed via x-ray. It has been one and a half years since the patient's injury. He has undergone an adequate course of conservative therapies without sufficient relief of symptoms. In light of these findings, I have determined that the patient meets ODG indications for the requested service, lumbar ALIF at L5-S1 (63090, 22558, 22851, 20931, 95920 x 2 LOS x 1 day). Therefore, the requested service is medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)

Vamvanij, V., et al. Quantitative changes in spinal canal dimensions using interbody distraction for spondylolisthesis. *Spine*, 2001.

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)