

Becket Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/03/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

22558 Anterior Lumbar Interbody Fusion @ Left L5-S1
22851 Apply Spinal Prosthetic Device
63090 Removal Vertebral Body
63091 Removal Vertebral Body, Addtl Level
20902 Removal Bone, Graft
38220 Bone Marrow Aspiration
77002 Needle Localization X-Ray
22612 Posterior Lumbar Decompression with Posterolaterl Fusions at L5-S1
63047 Removal Spinal Lamina
63048 Removal Spinal Lamina Add-On
22840 Insert Spinal Fixation Device
38220 Bone Marrow Aspiration
95937 Intraoperative Neuromuscular Junction Test
77002 Needle Localization X-Ray
99221 Inpatient Hospitalization: 2 Days

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

M.D., Board Certified Neurosurgery

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

The reviewer finds the request for 22558 Anterior Lumbar Interbody Fusion @ Left L5-S1 22851 Apply Spinal Prosthetic Device 63090 Removal Vertebral Body 63091 Removal Vertebral Body, Addtl Level 20902 Removal Bone, Graft 38220 Bone Marrow Aspiration 77002 Needle Localization X-Ray 22612 Posterior Lumbar Decompression with Posterolaterl Fusions at L5-S1 63047 Removal Spinal Lamina 63048 Removal Spinal Lamina Add-On 22840 Insert Spinal Fixation Device 38220 Bone Marrow Aspiration 95937 Intraoperative Neuromuscular Junction Test 77002 Needle Localization X-Ray 99221 Inpatient Hospitalization: 2 Days would not be supported as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes 04/23/09-05/27/09
Initial comprehensive evaluation 06/03/09 and 07/12/09
Electrodiagnostic studies 07/27/09

Clinical evaluation 08/14/09
Functional capacity evaluation 10/01/09
Physical performance evaluation 10/26/09
MRI lumbar spine 11/02/09
Clinical evaluation 11/09/09 and 01/15/10
Physical performance evaluation 11/19/09
Clinical evaluation 12/17/09-02/10/10
Functional capacity evaluation 12/17/09
Functional capacity evaluation 03/02/10
Individual psychotherapy notes 03/05/12-03/19/12
Employer's first report of injury or illness undated
Peer review 10/14/09
Physical therapy notes 01/24/12-03/06/12
Health and behavioral assessment 05/22/12
Radiographs lumbar spine 05/07/12
MRI lumbar spine 05/07/12
Operative report 11/30/11
Clinical notes 12/07/11-09/17/12
Prior reviews 08/03/12 and 08/29/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who has been followed for a long history of low back pain and radicular pain following a work related injury. The patient is status post lumbar microdiscectomy and laminectomy foraminotomy and partial facetectomy at L5-S1 on 11/30/11. Post-operatively the patient was reported to have complete resolution of low back pain and right lower extremity pain. The patient was noted to have undergone post-operative physical therapy through 03/12. The patient did report some low back pain to the right of the midline in 03/12 and the patient was seen on 04/19/12 with complaints of severe low back pain with extension of the right hip. Physical examination reveals loss of range of motion and muscular spasms. No focal neurological deficits were present. Updated MRI studies were recommended along with flexion extension views of the lumbar spine. Radiographs of the lumbar spine on 05/07/12 were normal. Repeat MRI of the lumbar spine dated 05/07/12 revealed a small disc protrusion at L5-S1 mildly impinging the thecal sac. There was a moderate to large region of enhancing scar tissue, which filled the entirety of the right lateral recess as well as the right nerve root. Follow up on 05/11/12 stated the patient continued to have no significant lower extremity symptoms but continued to have severe low back pain. Physical examination revealed mild weakness in the gastrocnemius musculature with some hypoesthesia in the right S1 nerve root distribution. The patient underwent a health and behavioral assessment on 05/22/12, which reported minimal depression and anxiety on BDI and BAI testing. FABQ scores for work was 18 and for physical activity was 21 no significant contraindications for surgical intervention were noted. The request for anterior lumbar interbody fusion at L5-S1 was denied by utilization review on 08/03/12 as there was no indication for one level fusion surgical intervention. The request was again denied by utilization review on 08/29/12 as lumbar fusion would not be indicated by Official Disability Guidelines.

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

The request for lone anterior interbody fusion at L5-S1 is not recommended as medically necessary based on the clinical documentation provided for review and current evidence based guidelines. Based on the clinical documentation provided for review there is significant enhancing scar tissue at L5-S1 to the right secondary to the prior surgical decompression in 11/11. The clinical documentation provided for review to include updated imaging studies, does not reveal any significant disc space collapse or motion segment instability at L5-S1 that would reasonably require lumbar fusion. Although the patient may benefit from further surgical considerations, the reviewer finds the request for 22558 Anterior Lumbar Interbody Fusion @ Left L5-S1 22851 Apply Spinal Prosthetic Device 63090 Removal Vertebral Body 63091 Removal Vertebral Body, Addtl Level 20902 Removal Bone, Graft 38220 Bone Marrow Aspiration 77002 Needle Localization X-Ray 22612 Posterior Lumbar Decompression with Posterolateral Fusions at L5-S1 63047 Removal Spinal Lamina 63048 Removal Spinal Lamina

Add-On 22840 Insert Spinal Fixation Device 38220 Bone Marrow Aspiration 95937 Intraoperative Neuromuscular Junction Test 77002 Needle Localization X-Ray 99221 Inpatient Hospitalization: 2 Days would not be supported as medically necessary.

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)