

Becket Systems

An Independent Review Organization
815-A Brazos St #499
Austin, TX 78701
Phone: (512) 553-0360
Fax: (207) 470-1075
Email: manager@becketsystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/2/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: L4-S1 mini 360 fusion with 2-day inpatient stay

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O. Board Certified Neurological 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is this reviewer's opinion that medical necessity is not established for L4-S1 mini 360 fusion with 2-day inpatient stay

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Physical therapy reports 02/29/12-03/12/12
Clinical records 05/25/12-02/01/13
Discography report 10/18/12
Psychological evaluation 12/04/12
Prior reviews 02/11/13 and 02/20/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xxxxx and has been followed for complaints of low back pain despite physical therapy in early 2012. The patient was seen on 05/25/12 with continuing complaints of low back pain. The clinical note indicated that the patient had a prior rhizotomy in 2007 which did not relieve pain. The patient was noted to be a ¾ pack per day smoker and the initial physical examination revealed no evidence of neurological deficits. There was pain and diffuse tenderness throughout the lumbar spine. The patient reported pain with flexion and extension that was slightly worse on extension. The patient was recommended for discography Radiographs were stated to show no evidence of instability. MRI studies were stated to show disc desiccation at L5-S1 with an annular tear at L4-5. No imaging studies were provided for review. The patient did undergo discography from L3 to S1 which reported concordant pain at L4-5 but non-concordant pain at L5-S1. No post-discogram CT studies were submitted for review. The patient was felt to be a good candidate for a hybrid artificial disc replacement at L4-5 with fusion at L5-S1. The patient underwent a psychological evaluation on 12/04/12 which revealed evidence of mild depressive symptoms on testing. The patient continued to have a smoking habit at this visit. opined that there were no contraindications for surgery at this point in time. continued the patient's Norco prescription in 01/13. The patient was seen on 02/01/13 with continuing complaints of low back pain radiating to the lower extremity. At this point in time, the patient was recommended for a 2-

level lumbar fusion at L4-5 and L5-S1.

The request for a 2-level fusion from L4-S1 was denied by utilization review on 02/11/13 as there was no evidence of positive exam findings for the levels requested, nor was there a preoperative psychological evaluation available for review.

The request was again denied by utilization review on 02/20/13 as no recent diagnostic testing was forwarded. Due to the lack of non-concordant pain on discogram, the reviewer felt that fusion at L5-S1 was not clinically indicated.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical documentation did not contain any imaging studies that revealed evidence of significant degenerative disc disease with disc space collapse, severe spondylolisthesis, or motion segment instability at L4-5 or L5-S1 that would reasonably require 360-degree lumbar fusion from L4-S1 followed by a 2-day inpatient stay. The patient did undergo discography which reported non-concordant pain at L5-S1; therefore, there is no indication from the clinical notes that the patient reasonably requires an L5-S1 fusion. The patient's prior conservative treatment was also not extensively documented. The patient was noted to have completed 8 sessions of physical therapy in early 2012; however, it is unclear whether the patient pursued any other active conservative management techniques for low back pain. Given the presence of what appears to be mainly axial low back pain, clinical literature has established that there are very poor outcomes from lumbar fusions in these types of cases. Given that the clinical documentation submitted for review does not meet current evidence based guidelines recommendations regarding lumbar fusion, it is this reviewer's opinion that medical necessity is not established for L4-S1 mini 360 fusion with 2-day inpatient stay at this time and the prior denials are upheld.

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)