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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/03/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar laminectomy discectomy spinal cord decompression and fusion and instrumentation of L4-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D. Board Certified Clinical 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 the opinion of this reviewer that the request for lumbar laminectomy discectomy spinal cord decompression and fusion and instrumentation of L4-S1 is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Notification of adverse determination dated 04/16/13
Notification of reconsideration determination dated 05/23/13
Post VD required medical examination dated 04/26/12
Designated doctor evaluation dated 02/09/12
Preauthorization request dated 02/20/13
Appeal request dated 04/11/13
Office notes 07/27/12 – 04/05/13
MRIs of the lumbosacral spine dated 02/17/10 & 02/23/12
EMG/NCV dated 03/31/10
X-rays of the lumbar spine flexion and extension views dated 02/23/12
Chronic pain management progress report dated 10/31/11
Office visit note dated 03/13/12
MRI of the thoracic spine dated 02/23/12

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a male whose date of injury is xx/xx/xx. Records indicate the claimant sustained multiple injuries when he slipped and fell. Records indicate the claimant has been treated with conservative care including physical therapy that helped; chiropractic treatment that did not help; TENS unit that did not help; massage therapy that did not help; and injections x 2 that did not help. MRI of the lumbar spine performed 02/17/10 revealed an L4-5 disc protrusion effacing the ventral thecal sac; L5-S1 large disc herniation with slight right paracentral orientation measuring 8mm. effacing the S1 nerve roots. Repeat MRI dated 02/23/12 revealed L4-5 minor 2mm. disc bulge effacing the ventral thecal sac; L5-S1 large right paracentral disc herniation measuring 7mm.

effacing the S1 nerve roots bilaterally, right greater than left. Electrodiagnostic testing was performed on 03/31/10 and reported findings consistent with right S1 radiculopathy. Flexion and extension x-rays of the lumbar spine on 02/23/10 revealed L5-S1 disc space narrowing, with no reported movement on flexion and extension views. Per the office note dated 04/05/13, the claimant continued with sharp pain to the low back radiating to the right hip with weakness and numbness of the right leg. It was noted that the claimant underwent lumbar laminectomy, discectomy, decompression, and foraminotomy at L4-5 and L5-S1 performed 06/17/11. It was noted the claimant has completed 20 days of chronic pain management program in October of 2011.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The claimant is noted to have sustained an injury when he slipped and fell. After undergoing a course of conservative care, the claimant underwent lumbar laminectomy, discectomy, decompression, and foraminotomy at L4-5 and L5-S1 on 06/17/11. The patient continues to complain of low back pain and right leg pain. Postoperative MRI dated 02/23/12 revealed a minor disc bulge at L4-5 with a large right paracentral disc herniation at L5-S1 effacing the S1 nerve roots. There was no evidence of motion segment instability on flexion and extension films. As noted on previous reviews, there is no documentation of motor or sensory deficits and specific nerve root distribution. Also, no presurgical psychological evaluation was documented. Based on the clinical information provided, it is the opinion of this reviewer that the request for lumbar laminectomy discectomy spinal cord decompression and fusion and instrumentation of L4-S1 as submitted does not meet Official Disability Guidelines criteria and medical necessity is not established for the proposed surgical procedure.

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)