

# Core 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Feb/28/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** L2-S1 posterior decompression & fusion w/L2/3 TLIF, inpatient 3 day length of 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 the opinion of the reviewer that medical necessity for L2-S1 posterior decompression & fusion w/L2/3 TLIF, inpatient 3 day length of stay is not established

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
Orthopedic physical therapy report 07/06/11  
Clinical records Dr. 06/07/11-09/23/11  
Procedure reports undated  
Handwritten progress notes with unclear signature 05/10/12 and 12/03/12  
Designated doctor evaluation Dr. 09/03/12  
Psychological evaluation 10/30/12  
Clinical records Dr. 05/09/11-01/09/13  
MRI lumbar spine 03/15/11  
MRI lumbar spine 07/11/12  
Electrodiagnostic studies 09/01/11  
Radiographs lumbar spine 09/07/12  
Radiographs lumbar spine 01/04/13  
Prior reviews 11/30/12 and 01/17/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who sustained an injury on xx/xx/xx while unloading PVC pipe. The patient returned to work the following day with complaints of low back pain. Conservative treatment to date included physical therapy for approximately 11 sessions and epidural steroid injections. MRI of the lumbar spine on 03/15/11 revealed disc space narrowing at L2-3 with decreased signal within the disc space. There was a diffuse disc protrusion extending into the canal with compression of the thecal sac centrally and to a greater extent in the left paramedian area. There was extension of the protrusion to the neural foramen bilaterally. Facet prominence and the disc protrusion

contributed to circumferential compromise of the canal with canal stenosis. Mild facet prominence was noted at L3-4. At L4-5, there was diffuse disc protrusion compressing the thecal sac. Limited extension of disc protrusion was noted into the neural foramen bilaterally. Facet hypertrophy and synovial cyst were present, extending anterior and medially compromising the canal. At L5-S1, there was significant degenerative change with a diffuse disc protrusion and an apparent extrusion of a fragment into the lateral recess at the S1 nerve root to the right side. Some thecal sac compression was present, however. There was no significant extension of disc protrusion to the foraminal neural foramen. Electrodiagnostic studies in 09/11 revealed no evidence for active lumbar radiculopathy with possible borderline early demyelinating neuropathy. The patient reported no long term improvement with physical therapy use of anti-inflammatories or epidural steroid injections. There was concern regarding possible pars defects and Dr. recommended the patient for updated MRI studies in 06/12. The new MRI study of the lumbar spine on 07/11/12 revealed mild disc desiccation and disc space decrease at L3-4 with mild impression of the thecal sac. There was facet arthrosis noted and mild neural foraminal narrowing was noted. The findings at L2-3 and L4-5 and L5-S1 were consistent with the previous study. No clear pars defects were identified in the study. Dr. felt that there were micro instability problems at L2-3 and L5-S1 requiring interbody fusion. Subsequently, the patient would require posterolateral fusion from L2-S1. The patient was seen for a designated doctor's evaluation by Dr. on 08/28/12. The report dated 09/03/12 identified diffuse paraspinal tenderness from L2-L5. There was limited range of motion secondary to pain and straight leg raise was reported as positive bilaterally in both sitting and supine positions. The patient demonstrated an antalgic gait and globally decreased sensation was present in the lower extremities. Mild weakness was noted on great toe flexion and extension bilaterally and there was hypersensitivity to touch in both feet. Mobility was severely limited and the patient was unable to perform heel and toe walking secondary to pain. No sensory deficits were present and strength in the lower extremities was intact. No apparent atrophy in the lower extremities was noted and reflexes were symmetric. The patient was found not to be at maximum medical improvement at this evaluation. Radiographs of the lumbar spine completed on 09/07/12 revealed hypertrophic changes at the facet joints at L4-5 and L5-S1. No anterolisthesis was present. The patient did undergo a psychological evaluation on 10/30/12. The report indicated that there were no contraindications for surgery. No MMPI-2 or BHI testing was apparent. Repeat radiographs of the lumbar spine completed on 01/04/13 identified spondylar arthropathy from L3-5 with hypertrophy of the facet joints at L4-5 and L5-S1. Clinical evaluation on 01/09/13 stated that the patient continued to have low back pain radiating through the lower extremities. The patient indicated that he was unable to walk more than a few steps before severe pain occurred in the anterior thighs, posterior thighs, and legs. The patient was recommended for interbody fusion at L2-3 and L5-S1 with posterolateral fusion from L2-S1.

This request was denied by utilization review on 11/30/12 as there was no documentation regarding instability.

The request was again denied by utilization review on 01/17/13 as the patient's pain generators had not been clearly identified and exam findings did not support medical necessity of the requested procedure.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** Per the clinical documentation provided for review, the patient has unclear exam findings. The patient's designated doctor's evaluation found no evidence of neurological deficits concordant with the patient's noted MRI pathology. The patient reported stocking glove-type sensory changes which are non-specific. There has been no attempt to clearly identify the patient's pain generators. Additionally, radiographs of the lumbar spine failed to identify any significant instability that would reasonably require a massive lumbar fusion from L2-S1. It is also of note that the patient's psychological evaluation was very limited and did not conclude any objective testing to confirm the lack of confounding issues for the patient. Overall, the patient is a poor surgical candidate based on the clinical documentation provided for review and the request is not consistent with guideline recommendations regarding lumbar fusion. As such, it is the opinion of the reviewer that medical necessity for L2-S1 posterior decompression & fusion

w/L2/3 TLIF, inpatient 3 day length of stay is not established 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)