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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/03/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Inpatient L3-S1 posterior fusion and L3-S1 anterior lumbar interbody fusion with a three (3) day length of stay

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D. 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 this reviewer that medical necessity for the requested Inpatient L3-S1 posterior fusion and L3-S1 anterior lumbar interbody fusion with a three (3) day length of stay is not established

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Physical therapy evaluation 10/31/08
Physical therapy evaluation 02/15/12
MRI lumbar spine 12/02/11
Radiographs lumbar spine 01/03/12
Radiographs lumbar spine 11/29/12
MRI lumbar spine 12/21/12
Radiographs lumbar spine 05/29/13
12/07 clinical record 12/07/12
Clinical record 01/11/13
Clinical record 04/29/13
Clinical record 06/18/13
Clinical record 12/10/13
Clinical record 02/08/13
Radiological review 02/05/13
Lumbar discography report 04/16/13
Psychological consult 02/15/13
Clinical record 11/30/11
Clinical record 09/11/13
Operative report 01/23/12
Utilization reviews 03/01/13-01/08/14

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx. The patient developed low back injury and was status post L4-5 laminectomy and decompression on 01/23/12. MRI of the lumbar spine on 12/21/12 demonstrated mild disc

desiccation at multiple levels from L3 to S1. There was more significant degenerative disc disease at L4-5 with post-operative changes consistent with bilateral laminectomies. There was some left lateral recess stenosis with possible mass effect at the traversing left L5 nerve root. Facet arthrosis was moderate to severe at this level. There was no evidence of canal stenosis at L4-5. At L3-4 there was severe facet arthropathy with disc bulging contributing to mild to moderate canal stenosis. No neural foraminal stenosis was noted at L3-4. At L5-S1 there was no evidence of canal or right neural foraminal stenosis. Due to lateral disc bulging there was a small amount of left neural foraminal stenosis. No subluxation was noted on flexion or extension views from radiographs in 05/13.

The patient underwent lumbar discography on 04/16/13 from L3 to S1. The patient reported positive concordant pain at all three levels. No control level was evident. The patient continued to report substantial low back pain without recurrence of leg pain. The patient was seen on 09/11/13 reporting continued low back pain with intermittent pain radiating to the lower extremities. The patient reported that it was difficult for him to bend twist or change positions and was unable to work out. Physical examination demonstrated limited range of motion of the lumbar spine. No neurological deficit was identified. did not recommend three level fusion but recommended a two level lumbar fusion from L4 to S1. The most recent assessment on 12/10/13 stated the patient continued to be functionally limited and had not improved with an extensive amount of conservative treatment including injections, physical therapy, or medications. Physical examination at this visit demonstrated no evidence of neurological deficit. The patient was again recommended for front to back lumbar fusion from L3 to S1. The requested anterior and lumbar anterior interbody and posterolateral fusion from L3 to S1 with a three day length of stay was denied by utilization review on 11/25/13 as there was no control level on the reported on the provided discography reports and there was no evidence for mechanical instability at either L4-5 or L5-S1. There was also no pre-operative psychological consult addressing any potential confounding issues as recommended by guidelines. The requested procedures were again denied by utilization review as there was no psychological clearance for the patient.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for continuing chronic low back pain following an initial lumbar decompression in 01/12. The provided discography report noted positive findings at all three tested levels without a control level. Therefore this discography report is essentially invalid as there was no control response. In regards to imaging there is no evidence of instability or severe spondylolisthesis at any level in the serve lumbar spine that would support lumbar fusion procedures as requested. The patient also did not present with any objective evidence of progressive or severe neurological deficit requiring extensive decompression followed by lumbar fusion. Furthermore the clinical documentation does not provide any pre-operative psychological consult which would address confounding issues that may possibly impact post-operative recovery as recommended by guidelines. Given the request is to address discogenic low back pain only psychological consults prior to surgical intervention would be appropriate. Therefore it is the opinion of this reviewer that medical necessity for the requested Inpatient L3-S1 posterior fusion and L3-S1 anterior lumbar interbody fusion with a three (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)