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Notice of Independent Review Decision

DATE OF REVIEW: February 25, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

One to two day inpatient stay for L4-5 disc replacement (22857, 77002).

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

M.D., Board Certified in Orthopedic 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)

The requested one to two day inpatient stay for L4-5 disc replacement (22857, 77002) is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 2/3/14.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 2/4/14.
3. Notice of Assignment of Independent Review Organization dated 2/5/14.
4. Denial documentation dated 12/17/13 and 1/15/14.
5. Pre-authorization request dated 8/21/13.
6. Letter dated 9/16/13.
7. Appeal Letter dated 1/10/14.
8. Notice of Independent Review Decision dated 3/25/09.

9. IRO review dated 3/24/09.
10. MRI of lumbar spine dated 10/6/09, 2/11/10 and 3/26/11.
11. Office note dated 4/18/11.
12. Operative report dated 10/13/09, 3/8/10, 5/12/11, 8/30/13 and 10/29/13.
13. Lumbar discography dated 8/30/13.
14. Office visit dated 12/5/08, 10/9/09, 10/26/09, 11/16/09, 11/13/10, 2/17/10, 3/21/10, 7/19/10, 8/11/10, 12/10/10, 5/29/13, 6/28/13, 7/29/13, 9/6/13 and 11/13/13.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported a work-related injury on xx/xx/xx. The patient was seen in clinic on 12/5/08 for evaluation of back and lower extremity pain. A magnetic resonance imaging (MRI) of the lumbar spine dated 10/6/09 revealed evidence of disc desiccation at both L4-5 and L5-S1 with a central disc bulge at L4-5 with an annular tear and a high intensity zone. At L5-S1, there was a right-sided disc herniation that caused compression of the thecal sac and nerve. On 10/13/09, he underwent a laminotomy and discectomy at L5-S1 with the use of a microscope. An MRI of the lumbar spine dated 2/11/10 revealed at L4-5 there was disc desiccation with a tiny 1mm posterior annular bulge accompanied by concentric annular fissure. He underwent medial branch blocks at L3, L4, and L5 nerve roots on 3/18/10. A subsequent MRI of the lumbar spine dated 3/26/11 revealed a minimal posterior disc protrusion that measured approximately 1mm at L4-5 that was stable compared to the previous exam. An electromyogram (EMG) performed on 4/18/11 revealed no evidence of peroneal neuropathy or other focal nerve entrapment, myopathy, acute lumbar radiculopathy or generalized peripheral neuropathy. The patient had surgery on 5/12/11 for an anterior lumbar fusion at L5-S1 with placement of interbody fusion cage and a partial vertebrectomy and decompression at L4-5 and S1. A discogram on 8/30/13 revealed concordant pain at L4-5. On 10/29/13, he underwent medial branch blocks of the dorsal rami of the bilateral L3, L4, and L5 nerve roots. The medical records dated 11/13/13, noted that he had a straight leg raise in the sitting position that was negative bilaterally. The record noted that Fabere test was negative bilaterally and sensation was within normal limits, and strength in all muscle groups tested in the bilateral lower extremities was 5/5. The patient also had a normal gait and stride and there was no evidence of instability or misalignment of the lumbar spine on exam.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Per the URA on 1/15/14 the patient's source for pain is not evident.

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

Official Disability Guidelines do not recommend disc arthroplasty at this time, indicating that it is not possible to draw any positive conclusions concerning its effect on improving patient outcomes. In this patient's case, the medical records submitted for review indicate that this patient has had multiple procedures on the lumbar spine, including medial branch blocks at L3, L4, and L5 nerve roots. A discogram showed concordant pain at L4-5, however, this request is for a disc arthroplasty at L4-5. Per ODG guidelines the surgical procedure requested is not considered medically necessary at this time; and therefore, a 1 to 2 day inpatient stay for the L4-

5 disc replacement would not be considered medically necessary as well. In accordance with the above, I have determined that the requested 1 to 2 day inpatient stay for the L4-5 disc replacement (22857, 77002) is not medically necessary for treatment of the patient's medical condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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 JUDGMENT, 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)