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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/29/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left L4-L5 laminectomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, Board Certified 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)

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 a Left L4-L5 laminectomy is not medically necessary.

PATIENT CLINICAL HISTORY: Patient is a female. On 03/11/15, she was seen in clinic for complaints of increasing back pain. On exam, she ambulated with a slow and deliberate gait and had tenderness to the left aspect of the low back and buttocks. On 04/09/15, an MRI of the lumbar spine revealed a grade 1 spondylolisthesis at L4 and L5 with very likely spondylolysis involving the PARS at L4. There was very severe compromise of the spinal canal at L4-5 with almost complete obstruction representing extreme spinal stenosis. This was secondary to a small canal further compromised by hypertrophic bone arising from the posterior elements. Ligament hypertrophy was noted with slight forward slippage of L4 on L5. There was moderate compromise of the lateral aspect of the right neuroforamen secondary to a very lateral right sided disc herniation and there was no compromise of the left neuroforamen.

On 05/06/15, the patient was seen in clinic for complaints of lumbar spine pain and left leg pain. She had a past medical history of diabetes and on exam, it was noted that patellar reflexes were 2+ bilaterally and Achilles reflexes were 2+ on the right and 1+ on the left. Straight leg raise was positive on the left. Strength deficits were noted in an L5 or great toe extensor pattern on the left rated at 4/5 and on the left foot eversion was rated at 3/5. Right lower extremity strength was 5/5. Sensation was stated to be diminished on the left. Surgery was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On 05/22/15, a utilization review report was submitted for the requested left L4-5 laminectomy with a lumbar brace and it was noted the request was non-certified. It was noted the request for surgery was reasonable but the use of a brace was not indicated. A peer-to-peer was not performed and therefore medical necessity of the entire request was not established and the request was non-certified. On 06/11/15, a utilization review determination for an appeal for a left L4-5 laminectomy was performed and it was noted there was a lack of documentation of previous epidural steroid injection as required or psychological screening. It was noted back braces were not approved for postoperative

laminectomy and would only be supported for a fusion. Therefore the request was non-certified.

The records submitted for this review note there is a spondylolisthesis at L4-5 with severe spinal canal stenosis and a very lateral right sided disc herniation without compromise of the left neuroforamen. The last note provided indicates the patient has left sided pathology with decreased reflex, decreased sensation and decreased motor strength. The records also failed to document an epidural steroid injection, or psychological screening. The records also indicate that the pathology is on the right side on the imaging study and the patient has left sided symptomology and objective findings. Therefore it is the opinion of this reviewer that the request for a Left L4-L5 laminectomy is not medically necessary 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)