

Core 400 LLC

An Independent Review Organization
3801 N Capital of TX Hwy Ste E-240 PMB 139
Austin, TX 78746-1482
Phone: (512) 772-2865
Fax: (530) 687-8368
Email: manager@core400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/09/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar laminectomy/discectomy/foraminotomy/facetectomy at L4-S1 x 1 day LOS

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 this reviewer's opinion that medical necessity in this case for the requested lumbar laminectomy/discectomy/foraminotomy/facetectomy at L4-S1 x 1 day LOS is established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx when he was involved in a motor vehicle accident. The patient initially sustained injury to the right shoulder which ultimately required arthroscopy for subacromial decompression, debridement of a labral tear, and repair of the rotator cuff completed on 12/16/13. The patient was also being followed for complaints of low back pain radiating to the left lower extremity. The patient's prior conservative treatment did include the use of anti-inflammatories as well as physical therapy through August of 2014. The patient did receive epidural steroid injections which provided temporary benefits only. Electrodiagnostic studies from 07/30/14 noted evidence for a right median nerve neuropathy. There was no indication of any radiculopathy on the study. Radiographs of the lumbar spine from 06/10/14 noted degenerative disc disease at L4-5 and to a lesser extent at L3-4 and L5-S1. There was a grade 1-2 retrolisthesis of L4 on L5 without acute fractures evident.

MRI studies of the lumbar spine completed on 06/10/14 noted disc desiccation and loss of disc height at L4-5 with a posterior disc protrusion present as well as bulging in the annulus compressing the left L4 nerve roots bilaterally, more severe to the left side than the right. There was mild to moderate central canal stenosis and lateral recess stenosis due to facet joint hypertrophy. At L5-S1, similar loss of disc height and disc desiccation was present with disc bulging extending to the left into the neuroforamen with compression of the left L5 nerve root. Bilateral foraminal stenosis due to facet hypertrophy was present. The patient was being followed for continuing complaints of low back pain radiating to the left lower extremity along the lateral thigh and calf and intermittently into the dorsum of the left foot. The patient continued to have symptoms despite conservative treatment. The patient's physical examination noted weakness of the left extensor hallucis longus, gastrocnemius, and tibialis anterior with reduced reflexes to the left ankle as compared to the right side. The patient had difficulty with heel and toe walking with a positive straight leg raise to the left at 40 degrees. There was sensory loss in an L5-S1 distribution.

The proposed decompression procedures at L4-5 and L5-S1 with a 1 day length of stay were denied on 09/15/14 as there was no documentation regarding previous non-operative treatment outcomes. There was also a lack of documentation regarding neurological findings on the most recent clinical evaluations.

The request was again denied on 10/03/14 as the last evaluation on 09/03/14 showed a normal neurological evaluation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for continuing complaints of low back pain radiating to the left lower extremity. The patient has undergone an extensive amount of conservative treatment to include the use of anti-inflammatories, physical therapy, and epidural steroid injections, all with temporary response. The patient's most recent physical examination findings did note weakness at the left extensor hallucis longus, tibialis anterior, and gastrocnemius. There was sensory loss in an L5 distribution as well as reduced reflexes at the left ankle. Straight leg raise findings were reported as positive to the left versus the right side. These physical examination findings do correlate with imaging that did note nerve root compression to the left at L4 and L5 due to a combination of degenerative disc disease and disc protrusions. In this case, given the failure of conservative treatment documented in the records as well as correlating objective evidence regarding a left L5 radiculopathy, the clinical records provided for review would meet guideline recommendations regarding the proposed decompression procedures at L4-5 and L5-S1. As such, it is this reviewer's opinion that medical necessity in this case for the requested lumbar laminectomy/discectomy/foraminotomy/facetectomy at L4-S1 x 1 day LOS is established for the requested surgical procedures. Given that the surgical procedures are indicated as medically appropriate, the requested 1 day length of stay would also be needed for postoperative assessments and the request is consistent with guideline recommendations. The prior denials are overturned.

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)