Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/26/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Minimal invasive anterior perinel approach L5-S1 arthrodesis with mini discectomy and lumbar brace with 2 days LOS 22558 22585 22845 22851 22612 22614 22840 20930 77002 95861 95920 L0637

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M. D. Board Certified Neurosurgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] 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 <u>each</u> health care service in dispute. It is the opinion of the reviewer that medical necessity is not established for the proposed Minimal invasive anterior perinel approach L5-S1 arthrodesis with mini discectomy and lumbar brace with 2 days LOS 22558 22585 22845 22851 22612 22614 22840 20930 77002 95861 95920 L0637.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Preauthorization determination 10/01/12
Preauthorization determination 11/07/12
Fax cover sheet/preauthorization request 09/26/12
Office visit notes Dr. 03/26/12 and 07/19/12
Psychological evaluation 09/15/12
MRI lumbar spine and sacroiliac joints 08/09/12
Fax cover sheet/preauthorization appeal request 10/08/12
Operative note cervical epidural steroid injection 10/24/11
Operative note lumbar epidural steroid injection 11/07/11
Operative note caudal epidural steroid injection 04/02/12
Physical therapy initial evaluation 08/09/11
Physical therapy re-evaluation 08/30/11 and 09/14/11

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant reportedly was injured secondary to a motor vehicle accident on xx/xx/xx. Per office note dated 03/26/12 the claimant presented with back pain/lumbar radiculopathy as well as neck pain. he also reported right upper extremity weakness that is not improving. The claimant had been treated with epidural steroid injections and multiple medications without relief. Lumbar MRI dated 08/09/12 reported mild right sided disc protrusion at L5-S1 with compression of the right S1 nerve root showing advancement since previous MRI of 08/03/11. No spinal stenosis was noted at this level. On

physical examination the claimant was noted to be 5’9” tall and 260 pounds. Motor strength was 5/5 throughout the bilateral lower extremities. Sensory was diminished in the left C5 distribution but intact in all other upper and lower extremity dermatomes. There was no tenderness to palpation in the lumbar or thoracic spine. There was no evidence of instability of the thoracic or lumbar spine. Repeat examination on 07/19/12 was unchanged except for diminished sensation noted in the right S1 distribution. The claimant was recommended to proceed with a minimally invasive anterior retroperitoneal approach L5-S1 Trans1AxiaLIF with posterior facet fixation. A psychological evaluation dated 09/15/12 determined that there were no psychological reasons why the proposed surgical procedure should be withheld.

A request for “minimal invasive anterior perinel (sic) approach L5-S1 arthrodesis with mini discectomy and lumbar brace with 2 days LOS” was reviewed on 10/01/12 and the request was denied noting that most recent clinical examination reveals that the claimant has normal strength and normal reflexes in the lower extremities, with decreased sensation in the S1 distribution on the right side, and that the records submitted for review discuss physical therapy and epidural steroid injections, but no ESI procedure notes and no physical therapy progress notes were provided. As the records failed to demonstrate exhaustion of conservative care, a decompression and fusion is not considered reasonable and necessary. Additionally it was noted that long-term studies have yet to be published to demonstrate the overall safety and effectiveness of the requested axial LIF versus standard surgical interventions.

An appeal request was denied on 11/07/12, noting that the previous reasons for non-certification remain unaddressed. It is unclear whether appropriate attempts at conservative care have failed. In addition, dynamic instability or spondylolisthesis with central stenosis is not evidence on imaging reports.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The claimant in this case was noted to have sustained an injury to the low back due to a motor vehicle accident. He complained of neck and low back pain and lumbar radiculopathy. MRI of the lumbar spine on 08/09/12 showed advancement of mild right sided disc protrusion at L5-S1 with compression of the right S1 nerve root, with no spinal stenosis noted at this level. On examination the claimant demonstrated normal motor and reflex functions, with diminished sensation reported in the right S1 distribution. The records submitted included procedure notes from cervical and lumbar epidural steroid injections, as well as physical therapy progress/evaluation notes. While it appears that the claimant may be a candidate for a simple decompression at the L5-S1 level, there is no evidence of motion segment instability or spondylolisthesis that would support the need for an anterior arthrodesis. As such, it is the opinion of the reviewer that medical necessity is not established for the proposed Minimal invasive anterior perinel approach L5-S1 arthrodesis with mini discectomy and lumbar brace with 2 days LOS 22558 22585 22845 22851 22612 22614 22840 20930 77002 95861 95920 L0637.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)