

SENT VIA EMAIL OR FAX ON
Nov/17/2009

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/17/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

2 day hospital stay and Excision Internal Fixation L3-S1

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

Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Operative report, 05/10/07

Office notes, Dr. 07/13/09, 09/28/09, 10/22/09

Hardware block, 08/31/09

Request for surgery, 10/07/09

Peer review, Dr. 10/13/09

Peer review, Dr. 10/22/09

PATIENT CLINICAL HISTORY SUMMARY

This male claimant reportedly sustained a slip and fall on xx/xx/xx which resulted in back pain. The records indicated that the claimant was diagnosed with lumbar spinal stenosis and radiculopathy and subsequently underwent a decompression and fusion L3-S1 on 05/10/07 with no complications reported.

A physician record dated 07/13/09 noted the claimant generally doing well two years post-operative except for some nagging, aching pain in the right low back. X-rays showed an

intact three level interbody fusions with no subsidence. On examination, there was tenderness over the paraspinal muscles. A hardware block was recommended and performed on 08/31/09. Seventy one percent reductions in pain was reported that lasted until the next morning. The treating physician determined that the claimant would be a candidate for excision of symptomatic retained internal fixation at all three levels bilaterally.

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

In this case, uneventful healing was noted after lumbar fusion. There is absolutely nothing to suggest that a pseudoarthrosis had developed or that insufficient time had been provided for the healing process. For persistent pain complaints, the treating physician provided appropriate diagnostic testing, including radiographs and a hardware block. The hardware block brought about substantial diminution of symptoms and, in fact, allowed the person to stop using medications. This relief apparently lasted until the next day.

This is a somewhat unusual case, but hardware blockade provides good evidence in the decision making process for the removal of potentially painful hardware. Given that this was removed over several levels, a two-day hospital stay for intravenous antibiotics, pain control, and wound management would have been perfectly acceptable. The Reviewer would recommend as medically necessary the proposed removal of hardware and the two-day stay.

The plain films would suggest against pseudoarthrosis. There is nothing to suggest any other complication, which would have precluded hardware removal. The response to hardware blockade provided significant substantiation in the treatment planning process.

The Spine. Rothman and Simeone Fifth Edition Chapter 93 p. 1540 – 154

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back: Fusion

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)