

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar revision, hardware removal, exploration and repair and implantable bone growth stimulator - 63042, 63044, 69990, 22612, 22851, 22938, 22842, 22558, 20975, 63685, 22325, 22852, 22830, D2990, ONEIA

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

M.D., Board Certified in Orthopedic Surgery
Board Certified in Spine 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determinations, 1/27/10, 2/3/10
M.D., P.A. 1/12/10
Pain Relief Clinic 12/16/09
IPain Management Center, 12/1/09
M.D. 10/14/09, 7/23/09, 8/19/09
M.D. 10/5/09, 9/29/09, 8/11/09
Physicians 1/27/10
Solutions 2/1/10
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who has undergone a previous lumbar fusion with hardware implantation and a bone growth stimulator, EBI type implantable unit. The patient complains of ongoing back pain. There is a diagnosis currently of painful lumbar hardware. There have been medial joint blocks at the level above the previous fusion at L3/L4 with considerable pain relief. A diagnosis of facet syndrome at L3/L4 apparently has been made and confirmed through medial branch blocks. Current request is for removal of hardware, exploration of fusion, probable refusion, and implantation of a bone growth stimulator.

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

Nowhere within the medical records is there is any evidence of pseudoarthrosis. There is also no evidence that an attempt has been made to determine whether or not the hardware or the suspected pseudoarthrosis is symptomatic. Hence, the hardware as the pain generator has not been addressed. There was not a thin sliced CT scan to confirm whether or not the fusion was solid or not. The only evidence presented in the records is that the patient is suffering from L3/L4 facet joint syndrome with excellent response to medial branch blocks. Given these findings, there is no indication for removal of symptomatic hardware, and there is certainly no indication for fusion per the ODG Guidelines for fusion. An implantable bone growth stimulator is not medically necessary in this case because it is only performed as an adjunct to spinal fusion surgery. Based on the medical records and the ODG, the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for Lumbar revision, hardware removal, exploration and repair and implantable bone growth stimulator - 63042, 63044, 69990, 22612, 22851, 22938, 22842, 22558, 20975, 63685, 22325, 22852, 22830, D2990, ONEIA.

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)