

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 3, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of the proposed inpatient L3-S1 revision laminectomy, discectomy, fusion with instrumentation, bone growth stimulator with implantable EBI and 2 day LOS (63042, 63044, 22612, 22614, 22851, 20975, 20938, 22842, 28558, 63685)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
847.2/ 729.2	63042		Prosp	1					Upheld
847.2/ 729.2	63044		Prosp	1					Upheld
847.2/ 729.2	22612		Prosp	1					Upheld
847.2/ 729.2	22614		Prosp	1					Upheld
847.2/ 729.2	22851		Prosp	1					Upheld

847.2/ 729.2	20975		Prosp	1					Upheld
847.2/ 729.2	20938		Prosp	1					Upheld
847.2/ 729.2	22842		Prosp	1					Upheld
847.2/ 729.2	28558		Prosp	1					Upheld
847.2/ 729.2	63685		Prosp	1					Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with a copy of the notice of utilization review findings offered by the organization. It is noted that the injured employee is a gentleman who sustained an injury on xx/xx/xx. A lumbar laminectomy with discectomy was performed. Subsequent to this procedure the claimant continued with pain. The physical examination findings and electrodiagnostic assessments demonstrate bilateral L5/S1 and L4 nerve root irritation. Postoperative imaging studies noted a disc herniation at L5 and multiple level bulges caudal. Dr. declined to endorse this multiple level fusion surgery.

A reconsideration was filed. The same medical history and findings on the physical examination were noted. Dr. also determined that this care was not reasonably required.

The request from Dr. was to complete a revision of the lumbar laminectomy, multiple level decompression, bilateral arthrodesis, and posterior and anterior instrumentation. With his November 8, 2011 progress note, Dr. reports a 5 mm and facet subluxation. However, no radiologic report is presented. This note also outlined that there is instability at L5/S1 and L3/S4. Secondary to this reported multiple level instability, fusion at the intermediary level would have to be done so as to prevent this injured worker from being "doom to failure".

An electrodiagnostic study was completed on August 10, 2010. This study identified minimal changes associated with lumbosacral radiculopathy.

Subsequent to this electrodiagnostic assessment, Dr. provided chronic pain management protocols to include medications, a functional capacity evaluation and work hardening. It was felt that there was lumbago, radiculopathy and status post L5/S1 discectomy.

The May 4, 2010 MRI reported the disc lesion at L5/S1. There was no evidence of instability or changes consistent with an instability identified with this enhanced imaging study.

The September 22, 2011 clinical evaluation completed by D.C. noted that the changes in the lumbar spine were primarily degenerative in nature. The physical examination noted this 5'9" 258 pound gentleman to be obese, with changes consistent relative to the lumbar surgery completed.

On October 13, 2011, there was a determination that maximum medical improvement had not been reached. There were ongoing complaints of low back pain, evidence of a failed back surgery syndrome, and interestingly enough no evidence of instability in the lumbar spine.

Dr. completed a pain management consultation and suggested a course of epidural steroid injections. Additionally, a psychiatric evaluation was completed on October 21, 2011. The postoperative epidural steroid injections and progress notes were reviewed.

On May 31, 2011, plain films of the lumbar spine were obtained. The lumbar curve was maintained. There was minimal spondylosis. The posterior elements were unremarkable. The titles were unremarkable. There is simply no indication of instability in the lumbar spine reported.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines, low back chapter updated December 15, 2011, the patient selection criteria for spinal fusion includes identification of wall pain generators that have been treated, all physical medicine and medical therapy interventions are completed, x-rays demonstrating spinal instability, MRI demonstrating disc pathology consistent with the symptoms on physical examination and spine pathology being limited to two levels.

Based on these criteria, it is clear that the pain generators have been identified and that the treatment has not been successful. However, there are no produced radiographs demonstrating spinal instability. All that is present is the presentation offered by the requesting provider in the face of multiple previous plain film studies, none of which have identified the reported instability. At a minimum, the requesting provider should have sent these films out for an independent assessment to objectify his notation. The MRI does demonstrate disc pathology; however, the pathology is more than two levels and should not be the basis for any future. Given the failure of every other methodology there simply is no data presented to suggest that this three level fusion procedure would have any efficacy whatsoever. To perform this procedure would clearly establish a lifelong pattern of pain complaints, disability and unnecessary functional compromise. As such, this request for a three level lumbar fusion surgery is not certified.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES