

Prime 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/11/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

inpatient two days with lumbar L2-L4 open 360 with hardware removal

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

M.D., Board Certified Orthopedic spine surgeon, practicing neurosurgeon

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.

The reviewer finds medical necessity does not exist for the requested inpatient two days with lumbar L2-L4 open 360 with hardware removal.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Medical records M.D dated 01/21/08
Operative report dated 08/16/10
Office visit notes M.D dated 10/29/10-05/23/12
MRI lumbar spine without contrast dated 11/05/10
Operative report dated 12/09/10
Designated doctor's evaluation 02/01/11
Radiographic report lumbar spine dated 02/15/11
Office visit notes D.O. dated 02/16/11-05/24/12
Radiology report AP and lateral flexion / extension views of lumbar spine dated 02/16/11
NM bone or joint 3 phase study dated 02/24/11
MRI lumbar spine with and without contrast dated 03/22/11
Utilization review determination dated 04/20/11
IRO review dated 07/12/11
Injured worker information sheet dated 12/29/11
Radiographic report lumbar spine 4 views dated 01/03/12
Behavioral medicine evaluation dated 06/12/12
Utilization review determination dated 07/27/12
Utilization review determination dated 08/20/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female injured on xx/xx/xx. She tripped and fell when she got her feet tangled. The claimant is status post L2-3 laminectomy / discectomy performed 12/04/2000. She underwent L2-3, L3-4, lumbar fusion on 10/18/02. She complains of low back pain radiating to the left lower extremities. Office note of 05/24/12 indicates the claimant has worsening low back pain. She is having difficulty with walking and using a cane to ambulate. She is noted to have pseudoarthrosis. There are pedicle screws placed L2-L4 which appear to be in good position, but Dr. states no fusion masses seen, no interbody fusion present and there is no fusion seen posterolaterally. He further noted there is some radial lucency around the pedicle screws at L4. Recommendation was for a revision of fusion, with interbody fusion.

A request for inpatient 2-day hospital stay with open 360 procedure with hardware removal for lumbar spine at L2-L4 was denied per utilization decision dated 07/27/12. The review noted the claimant presented with chronic low back pain and bilateral lower extremity symptoms and the absence of objective focal neurologic deficits. Claimant has had 2 previous lumbar operations, initially a left L2-3 discectomy performed 12/04/2000 and subsequent posterior decompression posterolateral bone fusion within instrumentation from L2-L4 on 10/18/02. Pain management notes of Dr. don't clearly define the claimant pain generators. Dr. most recent notes submitted dated 05/24/12 and notes a pseudoarthrosis with lucencies about the L4 screws. However, plain x-rays interpreted by Dr. on 01/03/12 makes no mention of this. There is no instability identified on the images. There have been no recent imaging studies in the form of MR or CT myelography. MRI of 03/22/11 showed a focal left L2-3 disc protrusion. Based on documentation and ODG treatment guidelines, the requested services are denied at this time. Consideration should be given to further/current imaging studies such as CT myelography, which would better define any bony pathology, assess abnormal movement (i.e. instability) and define evidence of nerve compression that correlates with clinical exam.

A reconsideration request for inpatient for 2 days of lumbar L2-L4 open 360 with hardware removal was denied per utilization review dated 08/20/12. It was noted the prior reviewer's non-certification was supported as there is no objectified documentation of pseudoarthrosis, radiolucency or failure or lumbar instability documented by any imaging studies. There are no clear ongoing assessments of motor or neurologic functions to the lower extremity denoted specified patterns of ongoing pain, motor or neurologic deficits. Peer review guidelines indicate that instability should be objectified by radiographic imaging. Also, the guidelines state lumbar fusion is indicated for lumbar instability and revision surgery for failed previous operations for the purpose of pain relief and must be approached with extreme caution due to less than 50% success rate reported in the medical literature. There should be x-ray documentation documenting spinal instability and or CT myelogram studies objectifying pathology which correlates with subjective complaints and examination findings, limited 2 levels and psychosocial screening performed with confounding issues addressed.

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

This claimant sustained a trip and fall injury in xxxx. She has undergone 2 previous surgical procedures to her lumbar spine with initial laminate discectomy performed 12/04/2000, and subsequent 2 level fusion L2-3, L3-4 performed 10/18/02. She continues to complain of low back pain. She underwent additional treatment including epidural steroid injection without significant improvement. Radiographs of the lumbar spine 01/03/12 revealed postoperative changes with presence of pedicular plate and screws fixing bilaterally at L2, L3, L4 levels in good position. There is degenerative disc disease seen at the bottom of the lumbar spine. Osteoporosis of all visualized bones was also noted. No other imaging studies were provided. According to Dr., the x-rays with 4 views clearly show a pseudoarthrosis; however, the radiography report does not document such findings. Without objective findings

demonstrating non-union/pseudo arthrosis, the proposed revision surgery cannot be considered medically necessary. The reviewer finds medical necessity does not exist for the requested inpatient two days with lumbar L2-L4 open 360 with hardware removal.

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)