

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/07/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: L3-5 hardware removal, exploration and possible revision, 2 day length of stay for spine surgery

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Neurological 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the requested L3-5 hardware removal, exploration and possible revision, 2 day length of stay for spine surgery is not indicated as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes 04/30/10
Clinical notes 05/05/10
Clinical notes 05/17/10
MRI lumbar spine 05/25/10
Clinical notes 05/26/10
Medical records reviewed 06/08/10
Clinical notes 06/23/10
Clinical notes 07/08/10
Clinical notes 07/14/10
Disability determination note 07/19/10
Clinical notes 08/03/10
Clinical notes 08/05/10
Procedure note 08/17/10
Clinical notes 09/07/10
Clinical notes 09/17/10
Chest x-ray 11/12/10
Operative procedure note 11/19/10
Clinical notes 12/08/10
Clinical notes 09/16/11
Clinical notes 10/27/11
MRI lumbar spine 02/02/11
MRI lumbar spine 03/03/11
X-ray lumbar spine 03/15/11
Clinical notes 03/29/11

Clinical notes 04/22/11
Psychological evaluation 05/19/11
Clinical notes 05/24/11
Clinical notes 05/26/11
Chest x-ray 07/27/11
Clinical notes 09/02/11
Operative note 09/02/11
Clinical notes 09/16/11
Clinical notes 09/28/11
Clinical notes 10/27/11
Clinical notes 12/21/11

INFORMATION PROVIDED TO THE IRO FOR REVIEW (cont):

Clinical notes 01/17/12
Clinical notes 02/02/12
Clinical notes 02/15/12
MRI lumbar spine 03/08/12
MRI lumbar spine 03/20/12
Clinical note electrodiagnostic testing 04/16/12
Clinical notes 04/25/12
Clinical operative note 05/02/12
Clinical notes 05/11/12
Impairment rating 05/30/12
Clinical notes 06/13/12
Clinical notes 06/20/12
Radiology exam 06/20/12
Behavioral medicine evaluation 07/09/12
Clinical notes 07/16/12
Clinical notes 08/07/12
Clinical notes 08/10/12
Clinical notes 08/24/12
Clinical notes 10/01/12
Clinical notes 10/17/12
Clinical notes 11/13/12
Clinical notes 12/03/12
Clinical notes 12/20/12
Clinical notes 01/11/13
Clinical notes 03/12/13
Operative note 03/12/13
Clinical notes 03/28/13
Clinical notes 05/21/13
Operative note 05/21/13
Clinical notes 06/19/13
Therapy notes 05/03/10
Therapy notes 05/05/10
Therapy notes 05/13/10
Therapy notes 05/17/10
Therapy notes 09/21/11
Therapy notes 09/23/11
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Therapy notes 11/18/11
Therapy notes 11/21/11
Therapy notes 11/22/11
Therapy notes 11/28/11

INFORMATION PROVIDED TO THE IRO FOR REVIEW (cont):

Therapy notes 12/05/11
Therapy notes 12/07/11
Therapy notes 12/09/11
Therapy notes 12/16/11
Therapy notes 12/19/11
Therapy notes 12/21/11
Therapy notes 12/27/11
Therapy notes 12/29/11
Therapy notes 01/03/12
Therapy notes 01/04/12
Therapy notes 01/09/12
Therapy notes 01/12/12

Adverse determinations 08/07/13 and 10/01/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported low back injury on xx/xx/xx. Clinical note dated 04/30/10 indicated the patient complaining of low back pain with associate stiffness. The patient also reported intermittent pain radiating into the back of the left leg. Upon exam range of motion limitations were noted with flexion to 30 degrees. Tenderness to palpation was noted. The patient was recommended for a physical therapy program at this time. The operative note dated 09/02/11 indicated the patient undergoing L3, L4, L5 laminectomy with a decompressive bilateral foraminotomy at L2-3, L3-4, L4-5, and L5-S1. Pedicle screw and rod system was implanted at L3-4 through L5 bilaterally. Posterolateral arthrodesis using an autograft bone from decompressive lumbar laminectomy and allograft bone from the allograft bone was completed L3 through L5. Clinical note dated 12/20/12 indicated the patient undergoing CT myelogram revealing good position of the implants. No loosening or subsidence was noted. No significant stenosis or neural foraminal stenosis was noted. Mild changes were noted with degenerative findings with mild stenosis in the neural foramen. The patient was recommended for hardware injection at this time. The patient was also provided with educational material indicating in order to find ways to quit smoking. Clinical note dated 01/11/13 indicated the patient complaining of low back pain on the left greater than the right. MRI revealed disc bulge. The patient also described left lower extremity spasms. The patient had a current smoking habit of one half pack per day. The patient had significant range of motion deficits secondary to pain throughout the lumbar spine. The patient also reported intermittent numbness and weakness. Pain radiated to the toes in the L4 and L5 L4, L5, and S1 derma distributions. Procedure note dated 03/12/13 indicated the patient undergoing epidural steroid injection at L3-4 and L4-5. Clinical note dated 03/20/13 indicated the patient stating the epidural steroid injection provided no significant benefit. Procedure note dated 05/21/13 indicated the patient undergoing hardware injection throughout at the lumbar spine. Clinical note dated 06/19/13 indicated the patient reporting a near 100% pain relief following hardware injection. The patient quantified the relief as 90-100%. Pain and tenderness continued at the hardware site. The patient was recommended for hardware removal with exploration of the fusion and possible revision. Therapy note dated 01/12/12 indicated the patient completing 39 physical therapy sessions to date. Behavioral medicine evaluation dated 07/09/12 indicated the patient being cleared for surgical intervention. The previous utilization review dated 08/07/13 resulted in a denial for the proposed hardware removal and fusion exploration with a revision as the proposed procedures were not supported as medically necessary. The medical necessity was not

established for an exploration of the fusion or possible revision secondary to a lack of evidence regarding any pseudoarthrosis. Utilization review dated 10/01/13 resulted in a denial as the information was lacking supporting objective symptomology indicative of additional surgical procedure within the lumbar spine. No information was submitted regarding recent formal recent completion of a course of formal therapy addressing the low back complaints.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: Clinical documentation submitted for review notes the patient complaining of low back pain. Hardware removal would be indicated provided that the patient meets specific criteria, including completion of all conservative measures and response to hardware block is appropriate. The patient had near eradication of pain upwards of 90-100%. No information was submitted regarding recent completion of any conservative treatment addressing the low back complaints. No symptomology was noted within the lumbar spine including pseudoarthrosis indicating the likely benefit of a surgical procedure including the proposed revision. Given these findings, it is the opinion of the reviewer that the requested L3-5 hardware removal, exploration and possible revision, 2 day length of stay for spine surgery is not indicated as medically necessary.

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)