IRO# 5356
5068 West Plano Parkway Suite 122
Plano, Texas 75093
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DATE OF REVIEW: 05/19/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

IRO - Exploration of Spinal Fusion/hardware removal for the lumbar spine.

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

This case was reviewed by a Texas licensed MD, specializing in Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ **Upheld**

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
IRO - Exploration of Spinal Fusion/hardware removal for the lumbar spine.	22830, 22850, 22852, 22855	-	**Upheld**

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request		17		
2	Diagnostic Test	Imaging	2	02/02/2010	02/02/2010
3	Diagnostic Test	Imaging Center	2	01/24/2008	01/24/2008
4	Op Report		6	10/26/2007	03/21/2008
5	Office Visit Report		20	04/14/2008	04/01/2010
6	Peer Review Report		12	02/23/2010	04/19/2010
7	Initial Denial Letter		6	04/08/2010	04/19/2010
8	IRO Request	Texas Department of	11	04/28/2010	04/30/2010

		Insurance			

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female with a history of a lumbar lifting injury on xx/xx/xx. She has undergone L4-L5 anterior and posterior instrumented fusion. Symptoms of low back pain and left leg pain have recurred and persisted in spite of chronic pain management including facet joint injections and local injections in the region of the pedicle screws. A recent MRI scan has suggested adjacent level degenerative disease at L3-L4 and L5-S1. Plain x-rays of the lumbar spine have confirmed that the lumbar fusion is solid. There is no evidence of disruption. Injections of the region of the internal fixation hardware have not been effective in alleviating her symptoms. Tension signs remain positive and recommendation was made to surgically explore the fusion and remove the internal fixation hardware. The request to preauthorize such a surgical procedure has been denied.

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

The plain x-rays, MRI and CT scans have repeatedly demonstrated that the fusion is solid. There is no indication that there is other pathology that might exist in or adjacent to the fusion site. There is no indication of infection or failure of the internal fixation devices. The local anesthetic injections in the region of the pedicle screws have not resulted in symptomatic relief.

The request for exploration of the spinal fusion site and removal of the pedicle screws L4-L5 is not medically necessary.

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

ODG; Back Chapter

Hardware injection (block)	Recommended only for diagnostic evaluation of failed back surgery syndrome. This injection procedure is performed on patients who have undergone a fusion with hardware to determine if continued pain is caused by the hardware. If the steroid/anesthetic medication can eliminate the pain by reducing the swelling and inflammation near the hardware, the surgeon may decide to remove the patient's hardware. (Guyer, 2006)

Guyer RD, Patterson M, Ohnmeiss DD. Failed back surgery syndrome: diagnostic evaluation. *J Am Acad Orthop Surg*. 2006 Sep;14(9):534-43.

Frymoyer, John W., MD, The Adult Spine, Principles and Practice, Chapter 99, Managementof Treatment Failures after Decompressive Surgery, pgs 2111- 2133.

- ☐ **ACOEM- AMERICAN 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**
- **X 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)**

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on 05/19/2010.