SENT VIA EMAIL OR FAX ON
May/03/2010

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Apr/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Inpatient lumbar surgery to revision lumbar spine surgery, hardware removal, exploration and repair

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

[ ] Upheld (Agree)
[X] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 3/30/10 and 4/7/10
Dr. 9/1/09 thru 3/16/10
OP Reports 2/23/10,3/3/10, 9/24/07
Dr. 1/11/10 thru 3/1/10
CT Lumbar 9/25/09
Spine & Ortho Institute 1/23/07 thru 1/20/09
MRI 9/11/06

PATIENT CLINICAL HISTORY SUMMARY
This is a male with a date of injury xx/xx/xx, when he fell. He underwent an anterior lumbar interbody fusion from L3-S1 with posterior pedicle screws on 09/24/2007. He complains of back and bilateral leg pain. His examination is unremarkable. A CT of the lumbar spine 09/25/2009 shows bilateral transpedicular screws at L5-S1. There was slight obliteration of the epidural fat on the right. Dr. believes there is bilateral S1 anterior screw penetration near the sympathetic chain. On 02/23/2010 a bilateral L2-L3, L3-L4, L4-L5, and L5-S1 hardware block was done. The provider notes 100% relief with the hardware block for 3 days. He recommends removal of hardware, exploration, and repair, as indicated. On the last visit to the original surgeon, Dr., 01/20/2009 it was recommended an infectious workup and workup for a pseudoarthrosis.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
The proposed surgery is medically necessary. If the claimant had had any infectious issues,

these would have become manifest by now. Removal of hardware is not specifically addressed by ODG. However, a hardware injection is addressed and is recommended as a means for determining whether a hardware removal would be beneficial for the patient's pain.

References/Guidelines

J Spinal Disord Tech. 2007 Jun;20(4):271-7. Safety and efficacy of implant removal for patients with recurrent back pain after a failed degenerative lumbar spine surgery. Alanay A, Vyas R, Shamie AN, Sciocia T, Randolph G, Wang JC.

Arch Orthop Trauma Surg. 2003 Oct;123(8):414-8. Epub 2003 Jul 31. Removal of lumbar instrumentation for the treatment of recurrent low back pain in the absence of pseudarthrosis. Wild A, Pinto MR, Butler L, Bressan C, Wroblewski JM.

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

[X] 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)