

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: November 22, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate).

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

M.D., Board Certified in Orthopedic 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)

The requested service, removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate), is medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 10/25/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 11/03/11.
3. Notice of Assignment of Independent Review Organization dated 11/03/11.
4. Preauthorization Request Forms from MD dated 4/14/11 and 10/07/11.
5. Medical records from MD dated 9/02/10, 10/18/10, 12/06/10, 2/10/11, 3/21/11, 4/11/11, 5/05/11, 6/08/11, 8/01/11 and 10/03/11.
6. Operative report from MD dated 4/05/11.
7. Myelogram report dated 4/05/11.
6. Report of CT lumbar spine with and without contrast dated 2/24/11.
7. Lumbar spine imaging dated 12/06/10, 12/07/10 and 10/03/11.
8. Discharge summary from Hospital dated 10/29/10.
9. Medical records from Hospital dated 10/27/10.
10. Operative report dated 10/27/10.
11. History and physical from Hospital dated 10/27/10.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. On 10/27/10, the medical records noted that the patient was status post L3 through L5 decompression, fusion and instrumentation for post-traumatic two-level disc pathology. The medical records noted adjacent level post-traumatic disease at L3 through L3, with instability, anterolisthesis, stenosis, herniated disc and root compression with neurologic deficit and chronic mechanical low back disorder. On 4/05/11, the patient presented with low back pain and leg pain. On 10/03/11, the medical records noted that lumbar spine x-rays showed what appeared to be good alignment and fusion. The patient requested to have his spinal fusion stimulator battery removed on this date (removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate)).

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested service. Specifically, the URA's initial denial stated that clinical examination did not reveal any significant reason for the requested service. The URA noted that the medical records did not demonstrate that the battery was displaced, and the records did not demonstrate pain from the spinal cord stimulator battery. On appeal, the URA indicated that there is no indication that the battery itself is causing problems.

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

The URA has indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested removal of the spinal fusion stimulator battery. However, the criteria

cited by the URA addresses spinal cord stimulation, not bone growth stimulators. The battery for bone growth stimulators should optimally be removed by the end of its useful life. As noted on the manufacturer's package insert for the bone growth stimulator, the effects of the long-term implantation of the generator have not been investigated. The current medical literature does not discuss the safety of indefinitely leaving this specific implant in a patient. In this patient's case, removal of the spinal fusion stimulator battery is medically indicated and appropriate.

Therefore, I have determined the requested service is medically necessary for treatment of the patient's medical condition.

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

- 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
- 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)