

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/10/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

2 INPATIENT surgical procedures: hardware removal fixation screws, retroperitoneal approach; 3 post-operative in-patient stay days; 1 surgical assistant

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

MD, Board Certified 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines

12/3/10, 12/14/10

2/3/09 to 12/1/10

MRI & Diagnostic 6/15/10

MRI 7/17/08 to 3/3/09

7/23/09

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury xx/xx/xx. He is status post L4-L5 fusion 09/09/2009. He developed a high white blood cell count, concerning for infection. A revision laminectomy and partial corpectomy along with a course of antibiotics was done to treat a possible infection. The provider states that the claimant has a metal allergy, as he had a titanium screw taped to the skin for four weeks and developed significant blistering and erythema around the site. A CT of the lumbar spine 06/15/2010 shows extremely subtle lucencies through the bony bridging at L4-L5. The provider is requesting hardware removal fixation screws and retroperitoneal approach with a surgical assistant and 3 postoperative inpatient days.

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

The proposed surgery is not medically necessary. The claimant has a suspected very unusual problem: allergy to the metal used in the spinal implant. However, no referral to an

allergist was done. A confirmation by an allergist that the claimant has, indeed, an allergy to the implant used is needed in order to establish the medical necessity of this case. According to the ODG, "Low Back" chapter, "all pain generators" should be "identified and treated". It is unclear that the hardware is a pain generator for him. Therefore, the surgery, at this time, is not medically necessary. The reviewer finds no medical necessity at this time for 2 INPATIENT surgical procedures: hardware removal fixation screws, retroperitoneal approach; 3 post-operative in-patient stay days; 1 surgical assistant.

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)