

Notice of Independent Review Decision

DATE OF REVIEW: 12/20/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient lumbar spine surgery: Removal EDI transmitter and electrodes, exploration and repair

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

The physician performing this review is a Diplomate of the American Board of Neurological Surgery. She is also a Juris Doctor. This reviewer had a clinic practice treating non-operative and operative peripheral nerve, spinal and cranial disorders in adults from 1989 until 2003. She has authored several publications. She presently consults in healthcare fraud and reviewing cases for standard of care, etc. She is licensed to practice medicine and law in the State of Texas.

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 or not medical necessity exists for each of the health care services in dispute.

The removal of the stimulator would be unnecessary surgery because there is no health gain and few but known complications.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records received: 18 page fax Texas Department of Insurance IRO request, 25 page fax, and 15 page fax on 12/10/10 URA response to disputed services including administrative and medical records.

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient, a woman, underwent an L4-5 and L5-S1 laminectomy and anterior and posterior fusions.

MW saw Dr. on xx/xx/xx with complaints of back stiffness.

The patient saw Dr. on 11/9/10 with a complaint of “pain about the EBI transmitter unit.” On exam MW had symmetric reflexes and no motor deficits. Lumbar x-rays showed no abnormal movements with EBI transmitter and electrode in good position.

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

The implanted device may be removed but should be done for benefit to the patient. There is no clear benefit for this patient. MW has chronic pain and there is no clear evidence that the stimulator is the cause of her pain. In fact, she appears to have a failed back syndrome and unfortunately will likely have chronic back pain.

In addition, the “exploration and repair as medically indicated” is not detailed or described and therefore cannot be determined to be medically necessary.

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)

REFERENCES:

- 1) John Sherman, Internal Bone Growth Stimulators for Spine Fusion (2002).
- 2) Rothman-Simeone, The Spine, 5th Ed. Vol. 1 Chapter 28 (p. 411)).