



Notice of Independent Review Decision

**DATE OF REVIEW: 7/07/2011**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

REMOVAL OF EBI TRANSMITTER AND ELECTRODE UNITS,  
EXPLORATION AND REPAIR WITH ONE DAY LOS (63688-99, 63650-50)

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

**M.D. Board Certified Orthopedic surgeon/ Fellowship Training  
Spine 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	6/17/2011
Corporation Preauthorization Determinations	6/02/2011-6/13/2011
M.D. PA Pre-Authorization Request Office Visits Appeals	1/11/2011-5/24/2011
Hospital Operative Report	12/27/2010



M.D. Clinical Note	6/11/2011

**PATIENT CLINICAL HISTORY [SUMMARY]:**

male s/p posterior lumbar decompression and fusion from L4-L5 to L5-S1 (date of surgery 12/27/2010) along with an implantation of bone growth stimulator. Clinical note on xx/xx/xx subjectively indicated the patient was working full time, on PRN pain medication, and without any significant complaints associated with the actual EBI unit. The notes’ final assessment was the patient was with “excellent result with retained symptomatic nonfunctioning bone growth stimulator.”

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

The removal of the EBI stimulator is not medically necessary.

There is no mention in the history exactly why the EBI transmitter and electrode units are being requested to be removed other than the unit is no longer working and indirect concern of a pseudoarthrosis. The patient appears to be doing clinically well based on his activity level, relatively absent subjective complaints, and physical examination positive only for maximal tenderness over the EBI unit with radiographs unremarkable for hardware complications and nonunion. There is no mention that the patient is complaining of hardware pain. There is no mention the unit is associated with an acute or chronic complication such as an infection, or potential injury to vital neurovascular bundles. There is no mention of a pseudoarthrosis radiographically or clinically to warrant removal of the stimulator and exploration of the fusion mass. There is no mention of diagnostic studies to identify the stimulator as a potential source of pain. Finally, there is no indication to explore the fusion mass five months postoperatively given minimal subjective complaints, lack of any diagnostic studies to warrant exploration such as a CT scan or radiographs documenting lack of bridging fusion bone mass.

REFERENCE: OFFICIAL DISABILITY GUIDELINES, LOW BACK CHAPTER, ONLINE VERSION



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**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: