

I-Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Sep/03/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpt Bone Fusion Stimulator Battery Removal 20680

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

MD, Board Certified in Neurological 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

Official Disability Guidelines

Adverse determination 07/25/11

Adverse determination 08/02/11

Operative report 07/19/05

Clinical records Dr. 05/22/08 through 04/25/11

CT myelogram lumbar spine 01/19/10

Admission history and physical 03/31/10

Operative report 03/31/10

Radiographic report lumbar spine 05/24/10

Clinical note Dr. 07/20/10

Operative report 04/04/10

CT of the cervical spine 01/04/11

Radiographic report lumbar spine 02/24/11

Radiographic report lumbar spine 04/25/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained an injury to his low back on xx/xx/xx. The first available clinical record is an operative report dated 07/19/05. On this date the claimant is noted to have severe L5-S1 disc space with grade 1 L5-S1 spondylolisthesis. He subsequently underwent a 360-degree fusion at this level. Subsequent clinical records indicate that the claimant had continued pain with recommendations by Dr. to perform a posterior L4-5 decompression fusion and instrumentation. Records indicate that the claimant underwent CT myelography on 01/19/10 which is reported to show bilateral L4-5 defects with stenosis and retrolisthesis of L4 on L5. No hardware complications were identified. Records indicate that on 03/31/10 he was returned to surgery and underwent an extension of fusion incorporating the L4-5 level. This again is reported to be a 360-degree fusion with instrumentation. Post-operatively he was reported to have improvement in his pain. He was noted to have good strength in the lower extremities. Radiographs of the lumbar spine were performed on 05/24/10, which note the claimant's hardware to be in place

as well as the presence of an internal bone growth stimulator. On 07/20/10 the claimant was seen by Dr. He is noted to have chronic back pain cervicalgia spasticity due to an on the job injury and significant disc disease. On physical examination he is reported to have decreased strength in the bilateral lower extremities graded as 3-4/5. He has decreased cervical flexion and extension with some increased tone in the left lower extremity. He was provided a prescription for Zanaflex and was to be referred for physical therapy.

The claimant was referred for CT of the cervical spine on 01/04/11 which notes severe disc space narrowing at C5-6 with large osteophytes.

Radiographs on 02/24/11 show laminectomies; partial facetectomies have been performed at L4-5 and L5-S1. Fusion appears to be satisfactory with the use of bony fusion masses interbody spacer components and pedicle screws. A stimulator remains in place. Repeat radiographs of the lumbar spine were performed on 04/25/11 which report potential loosening of the pedicle screws at L4 and may be a slight decrease in height at the disc of the disc space at L4-5. The vertebral end plates at L4 and L5 adjacent to the disc are slightly irregular. There was for removal of stimulator battery. The initial review was performed by Dr. on 07/25/11 who notes that the claimant has persistent low back pain and severe neck pain. There is no documentation of a recent comprehensive clinical evaluation from the provider or treating physician that addresses the proposed bone fusion stimulator battery removal on the last follow up note submitted. Also documented recent lumbar spine x-rays revealed instability in the fusion site with hardware loosening and loss of disc height. He opines that based on these grounds the medical necessity of the request is not established. A subsequent appeal request was reviewed on 08/02/11 by Dr. who notes that the appeal request for outpatient bone fusion stimulator battery removal is not medically necessary. He reports that the latest medical note does not contain clinical information from the provider or treating physician regarding a recent clinical assessment of the claimant that addresses the proposed service. He notes that the rationale for the request is not detailed in the report.

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

This claimant had low back pain as a result of a work related injury and ultimately underwent fusion at the L5-S1 level for instability. This was subsequently extended to incorporate the L4-5 level. The submitted serial notes from Dr. contain no significant objective data regarding the claimant's current status. There are no detailed physical examinations. Recent radiographs suggest the potential development of a pseudoarthrosis with hardware failure. The provider's notes provide no rationale for the request to remove the stimulator battery and it would not appear to be indicated in the presence of a developing pseudoarthrosis/hardware failure. The submitted clinical records do not provide sufficient data to establish the medical necessity of the request. At this time, the reviewer finds there is not a medical necessity for Outpt Bone Fusion Stimulator Battery Removal 20680.

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)