

SENT VIA EMAIL OR FAX ON
Mar/12/2012

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/12/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

63688 and 63660 Outpatient surgery for bone growth stimulator removal and electrode removal with 1 day LOS
Plus spine surgery to include 63011, 63042, 20938

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

Orthopedic spine surgeon, practicing 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)

63688 and 63660 Outpatient surgery for bone growth stimulator removal and electrode removal with one day inpatient stay is indicated as medically necessary

63011, 63042, 20938 Spinal surgery not medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Initial pre-auth utilization review 02/02/12

Appeal pre-auth utilization review 02/09/12

Appeal pre-auth utilization review 02/22/12

Pre-authorization request and appeal pre-authorization request

Manufacturer literature regarding recommendations explantation bone growth stimulator generator

Initial pre-auth utilization review 02/14/12

Office visit notes Dr.

New patient surgical consultation and follow-up 01/18/11-01/24/12

Operative report revision lumbar spine surgery decompression and fusion L4-5, L5-S1 07/29/11

Initial orthopedic consultation and subsequent medical report Dr. 06/08/10-10/12/10

Orthopedic comprehension consultation and follow-up note Dr. 03/03/11 and 03/31/11

Initial evaluation and follow-up Dr. 04/12/11 and 10/11/11

Pain management consultation and follow-up visits Dr. 04/28/10-06/23/10

Designated doctor evaluation Dr. 11/03/11

MRI lumbar spine 05/20/10

Designated doctor evaluation Dr. 12/29/10
Operative report left L4-5 laminectomy discectomy foraminotomy 08/19/10
Initial evaluation Dr. 04/23/10
Post designated doctor's required medical examination Dr. 07/29/11
Decision and order 09/09/11
Letter of verification 05/11/11
Designated doctor evaluation Dr. 04/22/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who was injured on xx/xx/xx when a lift gate malfunctioned and knocked him backwards into a brick wall. Records indicate the claimant had loss of consciousness. After failing a course of conservative care the claimant underwent left L4-5 laminectomy discectomy on 08/19/10. He subsequently underwent L3-4, L4-5 and L5-S1 laminectomy and discectomy with fusion at L4-5 and L5-S1 performed 07/29/11. The claimant was seen in follow-up by Dr. on 01/24/12. It was noted that the claimant was ambulatory without assistive devices and no antalgic gait. He is currently taking no medications. His only complaint is pain about the EBI transmitter unit site. He has no complaints of back pain, no complaints of leg pain and is ecstatic about his surgery result. X-rays of the lumbar spine including flexion extension views revealed L4-5 and L5-S1 decompression with global instrumented arthrodesis with two cross links in good position well healed with no motion on flexion extension views, no evidence of hardware loosening, failure or adjacent segment disease. On physical examination there is a well healed midline incision, point of maximum tenderness over the EBI transmitter unit. The unit was tested and is no longer functioning. The claimant was recommended to undergo outpatient surgery for bone growth stimulator and electrode removal as a recommendation and requirement of the manufacturer.

An initial pre-auth utilization review dated 01/30/12 recommended non-approval of removal of bone growth stimulator and electrode removal with one day LOS. The reviewer noted that Official Disability Guidelines does not specifically reference removal of stimulator but guides do not support unnecessary removal of devices as evidenced by Official Disability Guidelines position regarding hardware removal. An appeal pre-auth utilization review dated 02/09/12 determined request for outpatient surgery for bone growth stimulator removal and electrode removal with one day LOS plus spine surgery is not medically necessary. Reviewer noted that recent notes document x-rays that show good fusion status with no hardware complications. The claimant is about six months post revision surgery and moderate complaints of battery tenderness. It was noted that multitude of codes submitted to explore and take down the fusion as well as decompress nerve elements makes no clinical sense and might disturb what appears to be a good clinical result. As submitted the request is not necessary. At most removal of the battery only is reasonable. Appeal pre-auth utilization review dated 02/22/12 again recommended that the request for revision of removal of implanted spinal neurostimulator pulse generator receiver and revision of removal of spinal neurostimulator electrode percutaneous array or plate/paddle and one day LOS is not medically necessary. It was noted that the request is for removal of implanted bone growth stimulator, but the surgery codes requested were for removal of spinal cord stimulator. According to progress notes from 02/12 the claimant is doing well but only now some six months from extensive fusion surgery. Despite x-rays revealing no problem with minimal complaints offered by the claimant would warrant keeping the bone growth stimulator a while longer, possibly three more months before simply explanting the battery unit.

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

Based on the clinical information provided, the request for outpatient surgery for bone growth stimulator removal and electrode removal with one day inpatient stay is indicated as medically necessary; however, no further surgical procedures are warranted. The claimant is status post previous lumbar surgery including fusion at L4-5 and L5-S1 performed 07/29/11, with implantation of bone growth stimulator. Records indicate the stimulator is no longer functioning. The claimant complains of pain about the EBI transmitter unit site. He has no

other complaints of back pain or leg pain. Per the manufacturer's product information, it is recommended that the generator be removed at the end of its useful life (approximately 24 weeks). The literature further indicates that since the effects of long term implantation of the generator have not been investigated, the surgeon should carefully weigh the risk versus the benefits of explantation when deciding whether to remove the device. It appears that the claimant has very specific pain related to the bone growth stimulator, and removal is indicated as medically necessary. There is evidence of solid fusion and no evidence of hardware failure or other complications regarding instrumentation at the two fused levels. As such no further surgery beyond removal of BGS and electrode would be indicated.

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)