
ReviewTex. Inc.
1818 Mountjoy Drive
San Antonio, TX 78232
(phone) 210-598-9381 (fax) 210-598-9382
reviewtex@hotmail.com

Notice of Independent Review Decision

Date notice sent to all parties:

July 17, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Removal EBI Electrode Units – 63662-50, Removal of Implant, deep -20680, Exploration of, Arthrodesis-22830, Laminectomy-63011, Revision Lumbar Spine Surgery -63042, revision additional levels-63044 with 1 day LOS

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

Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Physical therapy reports 03/25/13 and 06/06/13
Operative report 01/10/13
Clinical notes 01/29/13-06/11/13
Prior reviews 06/17/13-06/18/13-06/25/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who initially sustained an injury on xx/xx/xx. The patient was

status post revision lumbar surgical decompression and fusion at L4 and L3-4 and L4-5 and L5-S1 on 01/10/13. Implantation of EBI bone growth stimulator unit was performed at this during this procedure. The patient was followed post-operatively and radiographs showed instrumented arthrodesis and decompression with good position of EBI transmitting unit electrodes. The patient was started on physical therapy in 03/13. Follow up on 06/11/13 stated that the patient was doing well with physical therapy. The patient reported some pain above the EBI transmitter unit and it was found to be no longer functioning. The patient was recommended for bone growth stimulator and electrode removal. Radiographs at this visit for the pelvis showed no evidence of degenerative joint disease within the hips or sacroiliac joints. Radiographs of the lumbar spine showed intact hardware at L4-5 with no evidence of loosening. Physical examination demonstrated tenderness over the EBI transmitter unit. The requested removal of EBI electrode unit, removal of implant, exploration of fusion, laminectomy, and revision of lumbar spine surgery with additional level were denied by utilization review on 06/17/13 as there was no indication for the revision procedures requested. The request was again denied by utilization review on 06/25/13 as there was no documentation regarding diagnostic hardware block and there was no documentation as to why revision procedures were needed or required.

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

The patient is status post revision lumbar fusion procedures in 01/13 with the placement of an EBI bone growth stimulator. The most recent evaluation indicated that the EBI transmitter was non-functioning and the patient had point tenderness over the transmitter unit. Based on review of the documentation there was no discussion or rationale regarding the submitted codes for revision laminectomy or lumbar spine fusion surgery or exploration of the prior fusion. There was no documentation regarding CT myelogram ruling out the presence of pseudoarthrosis. Given that the patient has complaints of pain over the non-functioning EBI transmitter unit removal of this unit only would be supported as medically necessary. Therefore it is the opinion of this reviewer that removal of the EBI electrode unit 63662-50 and removal of implant deep 20680 would be medically necessary only. The requested exploration of fusion 22830, laminectomy 63011, revision of lumbar spine surgery 63042, and revision additional levels 63044 are not medically necessary at this time. The removal of the EBI transmitter unit is essentially a very simple procedure and would not require one day length of stay. The procedure could be reasonably performed at an ambulatory surgery center.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines, Online Version, Low Back Chapter

Hardware implant removal (fixation)

Not recommend the routine removal of hardware implanted for fixation, except in the case of broken hardware or persistent pain, after ruling out other causes of pain such as infection and nonunion. Not recommended solely to protect against allergy, carcinogenesis, or metal detection. Although hardware removal is commonly done, it should not be considered a routine procedure. The decision to remove hardware has significant economic implications, including the costs of the procedure as well as possible work time lost for postoperative recovery, and implant removal may be challenging and lead to complications, such as neurovascular injury, refracture, or recurrence of deformity. The routine removal of orthopaedic fixation devices after healing remains an issue of debate, but implant removal in symptomatic patients is rated to be moderately effective. Many surgeons refuse a routine implant removal policy, and do not believe in clinically significant adverse effects of retained metal implants. For more information and references, see the [Ankle Chapter](#).