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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/26/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: inpatient lumbar surgery; removal EBI electrode units, removal of transmitter w/possible exploration of arthrodesis, laminectomy, revision lumbar spine surgery at L3/4 L4/5 w/ LOS x 1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O. Board Certified 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that the requested inpatient lumbar surgery; removal EBI electrode units, removal of transmitter w/possible exploration of arthrodesis, laminectomy, revision lumbar spine surgery at L3/4 L4/5 w/ LOS x 1 is recommended as a modified approval for the removal of the EBI transmitter leads only followed by a one day length of stay which would be supported by current evidence based guidelines.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical notes 12/13/11-04/23/13

Clinical notes 09/18/12-05/20/13

MRI lumbar spine 08/09/12

Chiropractic therapy reports 02/19/13-04/24/13

Operative report 11/16/12

Prior reviews 04/30/13 and 05/24/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx and was status post revision of a lumbar laminectomy and decompression at L4-5 with additional decompression at L3-4 followed by removal of posterior instrumentation at L4-5 and extension of fusion to L3-4 with new hardware placed from L3 to L5. The patient also had EBI bone growth stimulator unit implanted on 11/16/12. Post-operatively the patient was seen on 12/11/12 with a reduction in lower extremity swelling and pain. Radiographs showed instrumented fusion from L3 to S1 with EBI transmitting unit electrodes in good position. No motion was present on flexion or extension views. The patient saw following aquatic therapy for 24 sessions. The patient also completed 15 sessions of chiropractic therapy through 04/24/13. The patient reported stiffness and pain in the lumbar spine after prolonged standing. Physical examination on 04/24/13 demonstrated limited active range of motion in the lumbar spine with no evidence of neurological deficit. The patient was continued on medication management for pain. Clinical

record on 04/23/13 stated that the patient had continuing complaints of pain at the bone growth stimulator transmitting unit. Per the report the unit was no longer functioning and the patient was recommended for removal of this unit. The last clinical record on 05/17/13 stated that the patient continued to have complaints of low back pain after prolonged standing. This pain worsened with extension and twisting motion. Physical examination findings were relatively unchanged and the patient was recommended to continue with medication management. The requested lumbar surgery including removal of an EBI electrode unit removal of with exploration of lumbar fusion revision laminectomy was denied by utilization review on 04/30/13 as there was no evidence of further adjacent segment disease failure of hardware or any pseudoarthrosis to warrant the surgical request.

The request was again denied by utilization review on 05/24/13 as there was no evidence that the EBI stimulator was causing any mechanical symptoms or pain. Given that guidelines did not recommend routine removal of hardware and there was no evidence for exploration of fusion revision lumbar laminectomy or other spine surgery the request was denied.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient is status post multiple lumbar surgical procedures with the most recent procedure being performed in 11/12 where an EBI bone growth stimulator was implanted. The most recent evaluation indicated that there was tenderness over the EBI transmitter site and the unit was no longer functioning. The prior reviews denied the surgical request on the basis that exploration of fusion and revision lumbar laminectomy procedures were submitted. This reviewer would agree that there are no indications for any revision fusion or laminectomy procedures for this patient indicated for this patient as there is no evidence of further recurrent disc herniations or failed fusion at any level of the lumbar spine that would reasonably require revision procedures. It is the opinion of this reviewer that the removal of the EBI stimulator at this time would be medically necessary and appropriate. The EBI transmitter unit is not functioning and there is clear tenderness to palpation. Therefore it is the opinion of this reviewer that the requested inpatient lumbar surgery; removal EBI electrode units, removal of transmitter w/possible exploration of arthrodesis, laminectomy, revision lumbar spine surgery at L3/4 L4/5 w/ LOS x 1 is recommended as a modified approval for the removal of the EBI transmitter leads only followed by a one day length of stay which would be supported by current evidence based guidelines.

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)