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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jan/17/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Two day inpatient stay for lumbar removal electrode units of implant deep, exploration of arthrodesis, revision lumbar spine surgery, and revision additional level

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

Board Certified 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)

lumbar removal of electrode units of implant deep is medically necessary

exploration of arthrodesis, revision lumbar spine surgery, and revision additional level is not medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

MRI lumbar spine 12/22/10

Operative report 10/14/11

MRI lumbar spine 07/17/12

Clinical record 11/13/12

Clinical record 05/14/13

Radiographs thoracolumbar spine 08/05/13

MRI thoracic spine 08/05/13

MRI lumbar spine 08/05/13

Clinical record 11/05/13

Clinical record 11/08/13

Clinical record 11/26/13

CT scan review 11/27/13

Prior utilization reviews 12/05/13 and 12/16/13

Prospective review response 12/30/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx during a motor vehicle accident. The patient had a prior history of L4-5 lumbar fusion followed by placement of spinal cord stimulator. The patient was assessed with adjacent level disc disease at L3-4 and L5-S1 and underwent revision procedures on 10/14/11 that fused L3 through S1 segments. It also appeared that the previous spinal cord stimulator leads were revised with placement of external bone growth stimulator unit and leads. The MRI of the lumbar spine from 07/17/12 demonstrated Schmorl node formation at L2-3 with a broad mild broad based posterior central disc herniation. No canal or neural foraminal stenosis was identified at L2-3. The patient continued to describe axial low back pain which was improved with spinal cord stimulation. There was no evidence of lead migration on imaging from August of 2013. The updated MRI of the lumbar spine from 08/05/13 showed moderate to severe hypertrophic changes at L2-3 at the facets with a small amount of canal stenosis. There was moderate neural foraminal stenosis bilaterally that possibly contacted the exiting left L2 nerve root. Disc bulging and mild to moderate hypertrophic changes were present at L1-2. Prior operative changes from L3 to S1 were noted without evidence of hardware complications. There was a 1.4cm focus in the posterior soft tissues in the regions of the facet at L3-4 possibly consistent with a seroma versus a synovial cyst. This did not contribute to any canal or neural foraminal stenosis. The most recent evaluation on 11/26/13 stated that the patient had been recommended from had been recommended for removal of the entire hardware construct from L3 to S1 and removal of the spinal cord stimulator. The patient wished to have his spinal cord stimulator removed. Physical examination demonstrated absent posterior tibial tendon reflexes without motor deficits. There was paresthesia in the plantar aspect of the feet at S1. The patient was recommended for removal of spinal cord stimulator and electrodes. felt that on CT there was displacement of the spinal cord stimulator leads outside of their acceptable lead position. The requested removal of electrode and implants exploration of fusion and revision lumbar spine surgery with additional levels was not recommended as medically necessary by utilization review as there was no indication for any revision procedures for the lumbar spine. The determination was for removal of the wires and leads and pulse generator receiver. The requested services were again non-certified by utilization review as there was no evidence of any failure of lumbar hardware or pseudoarthrosis supporting revision or additional levels of lumbar spinal fusion procedures.

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

In review of the clinical documentation submitted for review, the patient has had multiple lumbar surgical procedures most recently being lumbar fusion from L3 to S1. Imaging showed evidence of adjacent level segment disc disease however there were no clear indications for any revision or exploration procedures or any revision of lumbar fusion at additional levels. The patient wished to have his spinal cord stimulator removed due to its non-functioning status and displacement of electrodes. Given that this patient has undergone two previous or one previous spinal cord stimulator placement that was also not successful, it is the opinion of this reviewer that the request be modified for certification of removal of the previous electrodes and pulse generator unit as this unit is non-functioning and would reasonably require removal. The requested exploration of fusion, revision lumbar spine surgery, and revision additional level is not medically necessary. The requested two-day inpatient stay would not be medically necessary, but modification to a 23-hour observation stay is medically necessary.

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)