

# P&S Network, Inc.

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**DATE OF REVIEW:** 07/23/2007

**IRO CASE #:**

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

This case was reviewed by a Pain Management Specialist. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

**DESCRIPTION OF THE SERVICE IN DISPUTE:**

10 DAY RENTAL OF BONE STIMULATOR

10 DAY RENTAL CRYO UNIT

**REVIEW OUTCOME:** UPHELD (agreed)

**REVIEW OF RECORDS:**

- o Submitted medical records were reviewed in their entirety.
- o June 7, 2007 notification of determination letter by M.D.
- o June 28, 2007 utilization review report by M.D.
- o Undated surgery pre-authorization form
- o May 8, 2007 surgery pre-op/admission orders sheet from Associates
- o May 8, 2007 report from Associates
- o March 27, 2007 patient questionnaires from Associates
- o May 2, 2007 CT myelogram of the lumbar spine report by M.D.
- o April 17, 2007 electrodiagnostic report from Associates
- o June 26, 2007 notification of determination letter from M.D.
- o March 27, 2007 report from Associates, M.D.

**CLINICAL HISTORY SUMMARY**

The patient is a male who sustained an injury on. According to a report dated, the patient injured himself on the job as he was lifting a heavy object. He initially had a laminectomy and decompression at the L4-5 level which failed to improve his condition. In November 1992, he went on to have a low back fusion over the L4-5 level done from the posterior and anterior approach. Over the last two years, he developed increasing low back pain radiating down the anterior thigh on the right side going towards the knee. In addition, he reported paresthesia and weakness in the right lower extremity.

Lumbar x-rays with flexion-extension views were performed on March 27, 2007 with reported findings of evidence of prior fusion at the L4-5 level with transfacetal fusions done with screw fixation and an anterior interbody fusion at L4-5. Retrolisthesis of L5 on S1 was noted with early narrowing of the disc space and deterioration of the facet joints at L5-S1 consistent with adjacent segment deterioration.

A CT myelogram was performed and revealed a high-grade block at the L3-4 level just above the prior fusion at the L4-5 level. With the CT portion of the study, disc space narrowing and retrolisthesis of L3 on L4 with a superimposed 9 mm broad-based right-sided posterolateral protrusion were noted, which markedly narrowed the right side foramen. There was evidence of displacement of the right L3 nerve root. It should be noted that in reviewing the CT myelogram lumbar report, the radiologist commented on a large mass measuring 59 mm transversely, which he stated was likely a left kidney cyst and ultrasound correlation was recommended.

On April 17, 2007, lower extremity electrodiagnostic studies were performed with an interpretation of chronic right L4 radiculopathy and chronic bilateral L5-S1 radiculitis, slightly worse on the left. In a May 8, 2007 report, the physician noted the combination of severe spinal stenosis at the L3-4 level with disc herniations at L2-3, L3-4, and L5-S1 and evidence of deterioration of the adjacent motion segments with respect to the fused area at L4-5. The physician recommended a wide decompression at the L3-4 level bilaterally with extension and fusion above the fusion to L3-4 as well as below to the L5-S1 level. At both levels, the physician recommended removal of the disc herniations.

On June 7, 2007, a request for an LSO brace, bone stimulator, and cryo unit rentals were non-certified. In addition, the requested surgery was non-certified and the Official Disability Guidelines were cited as the reason. The reviewer also noted that the claimant has had two prior surgeries to include fusion. The provider had identified radicular findings, but had not specifically identified instability. After speaking with the requesting physician, the reviewer noted that the patient does have some instability at the L3-4 level with an L4 radiculopathy. However, the reviewer stated that at the L5-S1 level, there did not appear to be any instability or radiculopathy. With that in mind, the request was non-certified.

A June 26, 2007 utilization review report rendered a non-certification for a 10 day rental of an LSO brace, bone stimulator, and cryo unit. The reason for the non-certification was provided as the records did not reflect that the proposed surgical procedure had been approved. Since the desired procedure was not yet certified, the post-operative durable medical equipment and care could not be certified.

### **ANALYSIS AND EXPLANATION OF DECISION**

10 day rental of bone stimulator: In my opinion, the non-certification of this piece of durable medical equipment should be upheld as the patient has not undergone the recommended lumbar fusion procedure at this time. This equipment is generally prescribed post-operatively.

10 day rental of cryo unit: The decision to non-certify this equipment is upheld as the medical literature has failed to find that these units are superior to standard, over-the-counter ice packs for the application of cryotherapy. In addition, as noted above, the patient has not yet undergone the proposed lumbar fusion procedure.

The IRO's decision is consistent with the following guidelines:

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE
- 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)

\_\_\_X\_OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

**GUIDELINES / REFERENCES:** BONE GROWTH STIMULATOR, LUMBAR

According to ACOEM guidelines, page 300, "passive physical modalities have no proven efficacy in treating low back symptoms. However, bone stimulator devices are usually indicated in patients who smoke, are elderly, have diabetes, have had multi-level fusions, or have had a failed fusion in the past".

According to the Official Disability Guidelines (2007), bone growth stimulator are under study. Some limited evidence exists for improving the fusion rate of spinal fusion surgery in high risk cases (e.g., revision pseudoarthrosis, instability, smoker). (Marks, 2000) (Akai, 2002) (Simmons, 2004) There is no consistent medical evidence to support or refute use of these devices for improving patient outcomes; there may be a beneficial effect on fusion rates in patients at "high risk", but this has not been convincingly demonstrated. (Resnick, 2005)

**GUIDELINES / REFERENCES:** CRYO UNIT

BlueCross BlueShield, Durable Medical Equipment Section - Cooling Devices Used in the Home Setting, DME Policy No: 7. Revised/Effective Date: 01/07/2005

The use of constant controlled cold therapy using units with pumps or portable refrigerators has not been shown to offer any clinically significant benefit over passive methods of delivering cold therapy. In summary, the available scientific literature is insufficient to document that the use of passive cooling systems is associated with a benefit beyond convenience, thus these devices are considered not medically necessary. Many of the published randomized studies failed to include the relevant control group of standard ice packs. Studies that did include a control group of standard ice packs reported inconsistent results, and some studies reported no significant benefit of passive cooling devices compared to no cold therapy. Active and passive cooling devices used in the home setting are considered not medically necessary.

The Regence Group: Blue Cross, Blue Shield Medical Policy. Durable Medical Equipment Section - Cooling Devices Used in the Home Setting. Policy/Criteria

Active and passive cooling devices used in the home setting are considered not medically necessary.