



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 10/8/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of DME - Bone Fusion Stimulator.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years in this specialty and performs this type of procedure in his office.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of DME - Bone Fusion Stimulator.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

, MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from : letter – 9/21/09, Denial letter – 6/29/09(x2) & 7/14/09; PRI Review Report – 6/29/09 & 7/10/09; Pre-authorization request – 6/24/09, letter – 6/17/09, Patient Daily Notes – 1/24/07; Health System Myelogram report – 2/19/07, Post Myelogram report – 2/19/07.

Records reviewed from , MD: Office Notes – 4/7/05-7/7/09, Operative Report – 8/9/05, 9/23/05, 4/14/06, 6/27/06, 7/20/07, & 12/16/08, Discharge Summary –

9/24/05, 6/29/06 & 7/14/06; , MD Myelogram report – 8/9/05 & 12/16/08, CT Evaluation – 8/9/05 & 12/16/08; x-ray report – 12/21/06; , MD radiology report – 6/29/07; , MD x-ray reports – 6/27/06; , MD Myelogram and Post Myelogram report – 4/14/06.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male. He injured his back at work while lifting. He was evaluated and found to have a L5-S1 HNP. Conservative treatment failed and he underwent L5-S1 left laminectomy and fusion on 9/25/05. He did well for several months then developed severe lumbar pain and underwent L5-S1 bilateral laminectomy, posterior and interbody fusion and instrumentation on 6/27/06. The patient continued to experience lumbar pain, but it was managed with conservative care and analgesics although he was unable to return to work. A myelogram CT on 12/06/08 revealed moderate central and foraminal stenosis at L4-5 and probable non-union at L5-S1 posteriorly. The patient has been noted by Dr. to have progressive neurologic deficit with increasing weakness.

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

The ODG states evidence exists for improving the fusion rate of spinal fusion surgery in high risk cases (e.g., revision pseudoarthrosis).

According to the ODG: Criteria for use for invasive or non-invasive electrical bone growth stimulators:

Either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with any of the following risk factors for failed fusion: (1) One or more previous failed spinal fusion(s); (3) Fusion to be performed at more than one level.

The patient meets the ODG criterion; therefore, the Bone Fusion Stimulator is medically necessary.

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 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)**