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Notice of Independent Review Decision

DATE OF REVIEW: 9/22/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of the purchase of a bone growth stimulator for the lumbosacral spine.

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 the purchase of a bone growth stimulator for the lumbosacral spine.

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 Request for Reconsideration/Appeal – 7/15/09, Spinal-Stim Order Form – undated; MD Referral Form – 5/19/09; Hospital Operative Report – 12/6/06(x2) & 3/9/06(x2).

Records reviewed from MD: Letter of Medical Necessity – 7/17/09, Follow-up Visit Notes – 7/22/08-7/7/09, Encounter Note – 1/16/09 & 2/18/09, Pre-op Diagnoses – 1/16/09, Post-op Diagnoses – 2/18/09, Peer to Peer report – 2/12/09, Multidisciplinary Case Management Conference report – 5/21/09, Radiographic Reading report – 7/22/08, 10/2/08, 2/5/09, & 4/2/09, Trigger Point Injection report – 7/22/08, Initial Visit notes – 5/8/08; MD MRI report – 3/31/09, Lumbar CT report – 4/27/09; MD Telephone Note – 5/19/09, EMG/NCS report – 3/26/09.

Records reviewed : Prescription for Gel – 5/19/09; Institute of Pain Management Referral Report – undated; Case Comments – 7/7/09 & 8/4/09, Notice of Denial letter – 7/2/09, Notice of Reconsideration – 8/3/09.

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 was injured at work xx/xx/xx and underwent multiple lumbar surgical procedures including L2-3 interbody fusion with cages in December 2006. The patient has recently developed a change in symptoms and workup has revealed an L2-3 non-union. A request has been made for a bone growth stimulator.

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

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). This patient has a confirmed non-union at L2/3 via the most recent workup. This meets the criteria for the requested service; therefore, it is approved as requested.

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)