

SENT VIA EMAIL OR FAX ON
Dec/06/2010

Independent Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (817) 349-6420
Fax: (817) 549-0311
Email: rm@independentresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/06/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

External Bone Growth Stimulator for Lumbar Back

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

Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines; Office notes, Dr. 09/07/10, 10/21/10; Operative report, Dr., 10/06/10; IRO Response 11/30/10; Denial Letters 10/20/10 and 10/29/10
Records 10/20/93 thru 4/9/1997

PATIENT CLINICAL HISTORY SUMMARY

This is a female who underwent removal of segmental instrumentation L3-L5, exploration of posterior spinal fusion L3-5l, laminectomy with facetectomy and foraminotomy, bilateral L2 decompression of significant lumbar stenosis, posterolateral fusion L2-3, non segmental instrumentation placement L2-3, transforaminal interbody fusion L2-3, insertion of interbody fusion cage L2-3, local autograft harvest and morselized allograft. On 10/21/10, Dr. noted that the claimant was a smoker and requested a bone growth stimulator.

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

The requested bone growth stimulator would be approved as medically necessary. Though it is only a one level extension, this is an individual who has undergone prior back surgery and currently smokes, thus a bone growth stimulator would be medically necessary. These factors are known risks for possible nonunion of a fusion.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter low back, bone growth stimulator

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); (2) Grade III or worse spondylolisthesis; (3) Fusion to be performed at more than one level; (4) Current smoking habit (Note: Other tobacco use such as chewing tobacco is not considered a risk factor); (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs. ([Kucharzyk, 1999](#)) ([Rogozinski, 1996](#)) ([Hodges, 2003](#))

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)