

Notice of Independent Review Decision
Amended Decision per carrier request

DATE OF REVIEW: 10/25/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for bone stimulator.

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

The physician performing this review is a licensed, practicing Orthopedic Surgeon. He is Board Certified, American Board of Orthopedic Surgery. He is a member of his local, state, and national medical associations. He has co-authored several publications. He has been in practice since 1992.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

A bone growth stimulator is recommended. The claimant underwent a two-level procedure from L4 to S1, a two-level fusion. This would meet the requirements based on Official Disability Guidelines for the use of a bone growth stimulator. The claimant has a history of smoking.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 14 page fax 10/13/10 Texas Department of Insurance IRO request, 58 page fax 10/13/10 Provider response with administrative and medical records, 36 page fax 10/13/10 URA Response to disputed services with administrative and medical records

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male claimant with a history of low back pain and bilateral lower extremity pain and diagnosed with lumbar radiculopathy, lumbago and status post lumbar discectomy surgery. The claimant subsequently underwent a transforaminal lumbar interbody fusion L5-S1 and L4-5 re-do hemilaminectomy, right L4-5 hemilaminectomy and redo left L5- S1 hemilaminectomy on 09/02/10. A physician letter dated 09/02/10 noted the claimant post lumbar fusion with fixation not optimal secondary to significant osteoporosis and the claimant with a history of smoking. A lumbar brace was recommended along with a bone stimulator due to the multilevel fusion. A cold therapy machine was also recommended to reduce pain and swelling.

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

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Low Back:

Bone growth stimulators (BGS)

Under study.

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.

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)

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