

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 04/30/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

DME bone growth stimulator E0748, DME Philadelphia collar, Aspen collar

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the DME bone growth stimulator E0748 is medically necessary to treat this patient's condition. However, the DME Philadelphia collar, Aspen collar are not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 04/14/10

- Letter of determination – 03/18/10, 04/11/10
- Prescription for DME – 03/12/10
- Operative report by Dr. – 03/15/10
- Letter of medical necessity by Dr. – 03/31/10
- Office visit follow up by Dr.– 01/15/10 to 03/12/10
- Copy of ODG-TWC guidelines for Neck and Upper Back – no date

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx resulting in injury to his cervical spine. He was diagnosed with herniated nucleus pulposis at C5-6 and C6-7. He underwent surgery on 03/15/10 and the treating orthopedic surgeon has prescribed DME bone growth stimulator E0748, DME Philadelphia collar and Aspen collar as part of the post-operative treatment.

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

The use of a bone growth stimulator is acceptable post multi-level fusion. This patient had a two level fusion. He also has the risk factor of smoking which inhibits bone growth. The patient with multi-level fusion is at higher risk of non-union and therefore use of the bone growth stimulator is justified by the ODG Guidelines. However, the use of collars for this patient is not justified. The patient has a stable fusion with the use of plates and the fusion status will not be further enhanced by the use of cervical collars. The ODG Guidelines do not justify the use of cervical collars.

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)