

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 18, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed bone growth stimulation system-Cervical spine (E0748)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.0	E0748		Prosp	1			8.3.2007	E2373256	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-20 pages

Requestor records- a total of 08 pages of records received from xxxx to include but not limited to: xxxx script 3.2.10; xxxxx records 8.26.08;xxxxx note 3.1.10

Requestor records- a total of 13 pages of records received from xxxxxx to include but not limited to: xxxxxx records 8.26.08-3.16.10; MRI L spine 8.26.08

Respondent records- a total of 21 pages of records received from the URA to include but not limited to: xxxxx records 3.3.10-4.12.10; xxxxxrecords 8.26.08-3.2.10; xxxxxnote 3.1.10; xxxxx letter 3.15.10; xxxxx script

Respondent records- a total of pages of records received from the Carrier to include but not limited to: Carrier letter 4.29.10 from Law Office of xxxxx records 3.3.10-4.12.10; xxxxx L.L.P records 8.26.08-3.2.10; xxxxx xxxxx note 3.1.10; xxxxx letter 3.15.10; xxxxx script; ODG Low Back and Pain

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with an operative report indicating a two level lumbar fusion surgery. The date of service for the surgery was March 1, 2010. A preoperative MRI of the lumbar spine noted, lumbar disc degeneration at multiple levels and a small disc protrusion at the lower level. Multiple progress notes completed prior to the surgery are identified. There is one progress note dated March 16, 2000 and indicating that the injured employee was two weeks since surgery and has been improvement in his preoperative pain. The wounds were noted to be clean and dry add follow-up radiographs noted the hardware to be intact and the fusion mass in proper position. There is absolutely no discussion of the indication for an osteogenic bone growth stimulator.

There is a form from the vendor asking for preauthorization, and reconsideration of the prior non-certification. There were no clinical notes provided to support this request. It was noted that the original request was for a cervical spine bone growth stimulator, this request is for a cervical spine and again there is no competent, objective and independently confirmable medical evidence presented to support the request.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines, This device is "Under study. There is conflicting evidence, so case by case recommendations are necessary (some RCTs with efficacy for high risk cases). Some limited evidence exists for improving the fusion rate of spinal fusion surgery in high risk cases (e.g., revision pseudoarthrosis, instability, smoker). ([Mooney, 1990](#)) ([Marks, 2000](#)) ([Akai, 2002](#)) ([Simmons, 2004](#)) There is no consistent medical evidence to support or refute use of these devices for improving patient outcomes; there may be a beneficial effect on fusion rates in patients at "high risk," but this has not been convincingly demonstrated. ([Resnick, 2005](#)) 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](#)".

While noting that there may be some indication for this device. Given the tobacco history and multiple level surgery, there are insufficient medical records presented to support the request. First of the request is for the cervical spine and the surgery was done on the lumbar spine. Second, the only progress note indicated that there was no indication for this device that the

fusion mass was in place and doing quite well. The reviewing provider attempted to contact the requesting provider and was not able to make contact. Given the complete lack of objective medical evidence, there is no clinical basis to support this request.

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
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)