

SENT VIA EMAIL OR FAX ON NOVEMBER 17, 2010

US Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/16/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bone growth stimulator, E0748

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

M.D., 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

ODG TWC LOW BACK

10/6/10, 10/14/10

M.D. 9/30/10

Spine Association 10/9/07 to 9/21/10

ROC-, PA 10/3/07 to 1/2/08

Clinical Progress Note 1/7/08

Surgical Hospital 6/29/10

Imaging and Diagnostic 6/15/07

Pain Care 9/10/10

PATIENT CLINICAL HISTORY SUMMARY

This is a patient injured on xx/xx/xx when he was struck on the left side of his body by a car. He has had 2 shoulder surgeries, physical therapy, injections, and work conditioning. He has also had knee surgery according to one note. His provider has recommended two-level lumbar fusion at L4/L5 and L5/S1 with instrumentation and 2 day inpatient stay. The medical

records indicate the patient has herniations at these levels. There is no instability seen. He is xx years of age. He was off work as of 9/10/10. This review is regarding the medical necessity of a bone growth stimulator.

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

This patient's medical records do not substantiate the required composites for a lumbar fusion at L4/L5 and L5/S1. There is no instability per AMA Guidelines. Therefore a bone growth stimulator is not medically necessary. Without surgical intervention the bone growth stimulator would not be particularly indicated. The reviewer finds that medical necessity does not exist for bone growth stimulator, EO748.

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)