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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Aug/15/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bone Growth Stimulator

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

Board Certified Neurosurgeon

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 medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Operative report dated 04/12/13

Prior reviews dated 06/24/13 & 06/26/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. It is unclear what the patient's mechanism of injury was. The patient was diagnosed with an L4 PARS fracture bilaterally as well as PARs fractures at L3. The patient has had a prior history of lumbar surgical procedures with a recurrent L3-4 radiculopathy. The patient underwent L3-4 and L4-5 facetectomy with foraminotomy bilaterally followed by lumbar interbody fusion as well as posterolateral fusion and posterior instrumentation on 04/12/13. There was a recommendation for a bone growth stimulator due to a multi-level fusion procedure.

The requested bone growth stimulator was denied by utilization review on 06/24/13. Per the report, in his discussion with the treating physician, the reviewer indicated that there was slight haloing around the stabilization screws. The reviewer felt that medical necessity had not been met as there were no medications or physical examinations provided for review as well as the lack of any imaging. There was no noted comorbidity such as smoking, renal disease, alcoholism, or significant osteoporosis to support a bone growth stimulator. The patient had a minimal risk due to a prior history of diabetes.

The request for bone growth stimulation was again denied by utilization review on 06/26/13

as there was no documentation regarding comorbid conditions such as smoking, renal disease, alcoholism, or significant osteoporosis.

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

Based on review of the clinical documentation submitted, the patient has had a prior history of multiple lumbar surgical procedures with further fusion performed from L3 to L5 on 04/12/13. Other than the remote history of diabetes indicated in the prior reviews, no additional clinical documentation was available for review to include preoperative evaluations or imaging. There is no evidence of comorbid conditions that would have reasonably resulted in an increased risk for pseudoarthrosis postoperatively such as alcoholism, renal disease, diabetes, or a smoking habit. There is no imaging evidence to support a diagnosis of pseudoarthrosis in the lumbar spine. As the clinical documentation provided for review does not meet guideline recommendations regarding increased risk factors for pseudoarthrosis postoperatively in lumbar fusion, it is this reviewer's opinion that medical necessity is not established at this time and the prior denials are upheld.

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)