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An Independent Review Organization
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AMENDED NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/15/2013

DATE AMENDED NOTICE SENT TO ALL PARTIES: Jul/24/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: outpatient bone growth stimulator and fitting for the low back

A 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that the request for outpatient bone growth stimulator and fitting for the low back is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Peer review dated 10/21/11
Peer review dated 04/12/12
MRI of the lumbar spine dated 04/18/13
Clinical note dated 05/09/13
Records review dated 06/12/13
Previous utilization reviews dated 06/04/13, 06/12/13, 11/12/12, & 04/11/13
Previous IROs dated 12/21/12, 06/07/13, 06/19/13, & 06/25/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his low back. The peer review dated 10/21/11 details the patient having been struck in the abdomen. The peer review dated 04/12/12 details the patient having sustained a multiple pelvic fracture and a sacral fracture through the foramina. The patient was also noted to have undergone a reduction of a dislocated left shoulder. The MRI of the lumbar spine dated 04/18/13 revealed an anterior spondylolisthesis of L4 over L5. Evidence of a bilateral spondylolysis was also noted at L4-5. Metallic hardware was noted at L5-S1. The clinical note dated 05/09/13 details the patient continuing with persistent symptoms. The patient described discomfort in the low back with an aching, stabbing, and burning sensation. The patient rated the pain as 4-5/10 at that time. The patient was able to demonstrate 5/5 strength throughout the lower extremities. Sensation was noted to be intact in the lower extremities with the exception of the L4-5 dermatomes in the left leg. Decreased reflexes were noted in the lower extremities.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient being recommended for a decompression surgery in the lumbar region. A bone growth stimulator would be indicated provided the patient meets specific criteria to include the patient noted to have a previously failed spinal fusion of 1 or more failed spinal fusions; a grade 3 or worse spondylolisthesis; a fusion to be performed at more than 1 level; a current smoking habit; or diabetes, renal, or alcohol involvement or significant osteoporosis demonstrated by radiographs. No information was submitted regarding the patient's significant findings indicating the need for a bone growth stimulator. No information was submitted regarding the patient's spinal fusion, grade 3 or worse spondylolisthesis, a fusion to be performed at 1 or more level, or a current smoking habit. Given that no information was submitted regarding the patient's significant clinical findings indicating the need for a bone growth stimulator, this request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for outpatient bone growth stimulator and fitting for the low back is not recommended as medically necessary.

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)