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Notice of Independent Review Decision

DATE OF REVIEW: February 9, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Purchase of cryotherapy unit, purchase of MLSO back brace and purchase of bone growth stimulator.

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

M.D., Board Certified in Orthopedic Surgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overtured (Disagree)**
- Partially Overtured (Agree in part/Disagree in part)

I have determined that the requested purchase of cryotherapy unit is medically necessary. The purchase of MLSO back brace is medically necessary. Additionally, the purchase of bone growth stimulator is medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained injuries to his right knee, right shoulder and low back on 1/24/11. On 10/30/14, the medical records noted low back pain which the patient rated as 10/10 and lower extremity numbness. The patient reported intermittent right knee pain and right shoulder pain which increased with activity. On 10/30/14, the provider's impression was increase in deformity status post lumbar fusion with loosening of hardware at L4-L5 and L5-S1, some nonunion of lumbar fusion, chondromalacia of the patella, improving, status post arthroscopy, and superior labral tear, right shoulder, status post shoulder arthroscopy. In a letter

dated 1/07/15, the provider's representative noted that the patient has been scheduled for a revision anterior/posterior lumbar fusion with re-instrumentation at L4-5 and L5-S1. A request has been submitted for purchase of cryotherapy unit, purchase of MLSO back brace and purchase of bone growth stimulator.

The URA indicated that the requested equipment does not meet Official Disability Guidelines (ODG) criteria. Specifically, the initial denial noted there was no documentation of a more recent evaluation from the requesting provider to support the request. Additionally, the URA noted that although continuous flow cryotherapy is recommended as an option after surgery, the duration of use was not specified. On appeal, the URA noted that the request is non-certified due to a lack of documentation of failed spinal fusion, and the guidelines do not recommend lumbar support for prevention or cryotherapy.

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

Official Disability Guidelines (ODG) support the bone growth stimulator in this patient's case. Per the guidelines, 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 one or more previous failed spinal fusion(s), grade III or worse spondylolisthesis, fusion to be performed at more than one level, current smoking habit, diabetes, renal disease, alcoholism or significant osteoporosis. In this patient's case, he is status post lumbar fusion at L4-L5 and L5-S1, and lumbar fusion with re-instrumentation at L4-5 and L5-S1 is planned. The submitted records also support the requested MLSO back brace in this patient's case. While ODG does not recommend lumbar supports for the prevention of pain, the literature indicates that there may be special circumstances in which some external immobilization may be desirable. This patient's records indicate that this is a complicated surgery which should be considered an exception to the guidelines. The current evidence supports the cryotherapy is a recommended options for acute pain. Thus, there is support for the requested cryotherapy unit in this patient's case.

Therefore, I have determined the requested purchase of cryotherapy unit is medically necessary. Additionally, the purchase of MLSO back brace is medically necessary. The purchase of bone growth stimulator is medically necessary for treatment of the patient's medical condition.

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 JUDGMENT, 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)
 1. Zhang, J., et al. Effects of Biofreeze and chiropractic adjustments on acute low back pain: A pilot study. *J Chiropr Med*, 2008 Jun;7(2):59-65.
 2. Resnick, J., et al. Guidelines for the performance of fusion procedures for degenerative disease of the lumbar spine. Part 8: Lumbar fusion for disc herniation and radiculopathy. *J Neurosurg Spine*, 2005 Jun;2(6):673-8.
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)