

# **Applied Assessments LLC**

**An Independent Review Organization**

**Phone Number:**  
**(512) 333-2366**

**2771 E Broad St. Suite 217 PMB 110**  
**Mansfield, TX 76063**  
**Email: [appliedassessments@irosolutions.com](mailto:appliedassessments@irosolutions.com)**

**Fax Number:**  
**(512) 872-5096**

## **Notice of Independent Review Decision**

### **Review Outcome:**

**A description of the qualifications for each physician or other health care provider who reviewed the decision:**

Neurosurgeon

### **Description of the service or services in dispute:**

DME/NU Bone growth stimulator

**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)

### **Patient Clinical History (Summary)**

This patient is a woman with complaints of back pain. On 01/15/15, the patient was seen in clinic, and had decreased strength in the EHL, gastroc muscles on the left, and had a hypoesthetic region in an L5 and S1 distribution on the left. A decompression and fusion at both L4-5 and L5-S1 was recommended and described. On 12/10/14, a utilization review determination for the requested anterior lumbar fusion at both L4-5 and L5-S1 with posterior lumbar fusion and decompression, noted the request was medically necessary.

### **Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.**

On 01/20/15, a utilization review determination for the requested bone growth stimulator utilized Official Disability Guidelines noting that guidelines stated this device is under study. However, if the patient was at risk, having 1 or more previous failed spinal fusions, grade 3 or worse spondylolisthesis, or if a fusion was to be performed at more than 1 level it could be reasonable. It was noted in that case there was no evidence of any increased risk of non-healing and therefore the request was non-certified. On 01/23/15, a utilization review determination stated the requested procedure was not medically necessary.

The submitted records indicate the patient has been advised to undergo a 2 level lumbar fusion both anterior and posterior. The Official Disability Guidelines low back chapter indicates that bone growth stimulators are currently under study with conflicting evidence so case by case recommendations are necessary. However, they list criteria for use of invasive or non-invasive electrical bone stimulators as a fusion that is performed at more than 1 level, or a current smoking habit or evidence of diabetes, renal disease, or significant osteoporosis. For this patient, she would have a fusion at more than 1 level. Therefore, it is the opinion of this reviewer that the request for DME NU bone growth stimulator is medically necessary and the prior denials are overturned.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPH-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- 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 and Treatment
- Guidelines Pressley Reed, the Medical Disability
- Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)