



**RO REPORT**

**DATE OF REVIEW:** 6/12/07

**IRO CASE #:**

**NAME:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Determine the appropriateness for the previously denied request for EBI BHS Orthopak Bone Growth Stimulator for the Tibia/Fibula.

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

Texas Licensed D.O., 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)

The previously denied request for EBI BHS Orthopak Bone Growth Stimulator for the Tibia/Fibula.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- E-Mail Message dated 7/9/07, 1 page.
- Fax Cover Sheets/Comments dated 5/31/07, 5/29/07, 5/25/07, (unspecified date) 7 pages.
- Fax Cover Sheet/Appeal/Reconsideration Request dated 4/24/07, 1 page.
- Notice to Inc. of Case Assignment dated 5/25/07, 2 pages.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 5/21/07, 1 page.
- Company Request for Independent Review Organization dated 5/14/07, 4 pages.

- **Request for a Review by an Independent Review Organization dated 5/10/07, 3 pages.**
- **Peer Review Determination dated, 3/29/07, 6 pages.**
- **Fax Cover Sheet (unspecified date), 1 page.**
- **Examination/ Note dated 4/19/07, 3/2/07, 2/1/07, 1/22/07, 4 pages.**
- **Prescription/Authorization Request dated 3/22/07, 1 page.**
- **Operative Report, 1 page.**
- **Patient/Insurance/Medical Data Sheet (unspecified date).**
- **Request for Reconsideration (unspecified date).**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

**Patient's age:**

**Gender:** Male

**Date of Injury:**

**Mechanism of injury:** Not provided for review.

**Diagnoses:** Fracture shaft tibia and fibula; external fixation; nonunion fracture tibia and fibula

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

The peer review performed indicated debridement of the fracture with external fixator applied and a note indicated that the claimant was doing well with some lateral side pain, but doing better. After discussing the case with the treating doctor on 3/28/07, it was noted that there was some healing and the external fixator had been adjusted and the treating physician agreed with the reviewer that the stimulator was not indicated at that time due to no non-union being present. On 5/1/07, a new review was performed and the stimulator again was not recommended. The criteria for use of a bone growth stimulator was given as non-union of a long bone fracture (5-10% exhibit signs of delayed or impaired healing) and all of the following: The bone is not infected; AND the two portions of bone involved in the nonunion are separated by less than 5 mm; AND the bone is stable at both ends by means of a cast or fixation; AND a minimum of 90 days has elapsed from the time of the original fracture. There were no X-ray reports submitted for the review performed on 4/30/07 that indicated a non-union. It noted that the fracture had apparently progressed with non-alignment, and surgery was scheduled to remove the external fixator and attempt reduction with intermedullary nailing for better fixation. The requested bone growth stimulator, despite the claimant's history of smoking, is premature at this time and not medically necessary based on the Official Disability Guidelines. The rationale for non-certification of the requested bone growth stimulator for the tibia and fibula is that the medical records provided for review did not contain radiographic reports or treating physician reports that indicate a non-union which would support the need for the bone growth stimulator, and if the patient is scheduled to undergo an open reduction internal fixation (ORIF) with intermedullary rodding, then the bone growth stimulator request is not necessary at this time.

**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 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, 2006/2007.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHRIOPRACTIC 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).