



Notice of Independent Review Decision

**IRO REVIEWER REPORT**

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**DATE OF REVIEW:** 4/7/08

**IRO CASE #:**

**NAME:**

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

Determine the appropriateness of the previously denied request for EBI OrthoPak Bone Growth Stimulator.

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

Texas licensed 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 or not medical necessity exists for each of the health care services in dispute.

The previously denied request for EBI OrthoPak Bone Growth Stimulator.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Confirmation of Receipt of a Request for a Review dated 3/27/08.
- Notice to CompPartners dated 3/27/08.

- Request Form dated 3/13/08.
- Fax Cover Sheet/Comments dated 3/17/08, 1/9/08, 1/2/08.
- Bioelectron Stimulators dated 3/4/08, 12/18/07.
- Notice of Assignment dated 3/27/08.
- Request for Certification dated 3/20/08, 1/7/08.
- Request for Reconsideration dated 1/15/08.
- Physical Examination Follow-Up dated 2/15/08, 1/28/08, 12/17/07, 11/6/07, 10/24/07.

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:** xx years

**Gender:** Male

**Date of Injury:** xx/xx/xx

**Mechanism of Injury:** Motor vehicle accident.

**Diagnosis:** Distal clavicle fracture with CT evidence of delayed union.

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

The patient is a xx-year-old male with the date of injury of xx/xx/xx. The mechanism of injury was a motor vehicle accident. The diagnosis was distal clavicle fracture with CT evidence of delayed union. The patient originally was treated conservatively. Dr. evaluated the patient on October 24, 2007, noting the prominence of the left distal clavicle with pain on palpation. The patient was followed by Dr. also for treatment of the right knee injury sustained in the accident. The patient has not shown normal bone healing during this follow-up. As of Dr. most recent note on February 15, 2008, the claimant was still symptomatic, with evidence of delayed union at a portion of the fracture with ongoing pain. The possibility of operative intervention was noted. The Official Disability Guidelines (ODG) indicate bone stimulators are an option for nonunion long bone fractures after a minimum of 90 days. This patient has well passed the 90 days and does have what would now be considered nonunion. While the patient is to undergo an open reduction internal fixation (ORIF) due to this being a delayed union, the bone stimulator would be appropriate and in line with the ODG and with generally accepted standards of care in orthopedic surgery. As the patient does have a longstanding (6 months) nonunion and in an attempt to obtain a solid union by utilizing all measures possible, this reviewer does feel the bone growth stimulator would be appropriate.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disability Guidelines (ODG), Treatment Index, 6<sup>th</sup> Edition (web), 2008, Forearm, Wrist, & Hand—Bone-growth stimulators

- 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).