

# US Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE OF REVIEW:

Aug/13/2009

### IRO CASE #:

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

DME Osteogenic Non-invasive Ultrasound Stim. (E0760)

### 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)

### INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Office notes, Dr., 3/2/09, 04/20/09, 05/13/09, 06/08/09

Peer review, Dr., 6/1/09

Appeal letter, Dr., 6/2/09

Peer review, Dr., 7/2/09

### PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx year old male who sustained a fifth metatarsal base fracture on xx/xx/xx. The claimant was treated with a pneumatic fracture walker and non weight bearing. X-rays were done on 03/02/09, 04/20/09, 05/13/09, and 06/08/09. X-rays on 04/20/09 revealed a fifth metatarsal base avulsion fracture that was intra articular, minimally displaced only on the lateral border approximately 2-3 mm. X-rays on 05/13/09 showed approximately 40% healing medially. The 06/08/09 x-rays showed no displacement on the medial edge of the fracture but there was a 4 mm displacement (proximal distraction) of the lateral edge of the fracture. There had been no change in the last three x-rays. An Exogen bone stimulator was placed at that visit.

### ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

Purchase of a bone growth stimulator is not medically indicated and appropriate in this patient. This is a xx year old who is a heavy tobacco smoker who has mild pain subjectively

and pain over the fifth metatarsal. There is a 4 millimeter displacement of the lateral edge of the fracture, a notable change. Given the paucity of subjective complaints, and smoking in combination with the absolute displacement, a bone growth stimulator is not indicated and appropriate. The request does not conform to the ODG criteria for the use of ultrasound bone growth stimulators. The reviewer finds that medical necessity does not exist for DME Osteogenic Non-invasive Ultrasound Stim. (E0760).

**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)