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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 2/26/09

**IRO CASE #:**

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

Removal of left foot bone growth stimulator

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

Board Certified in Orthopaedic Surgery

**REVIEW OUTCOME**

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

Upheld (Agree)

**X 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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse determination letters 2/3/09, 2/2/09, 1/14/09  
Lt 1/26/09, Dr.  
Post operative clinic notes, 2/10/09 2/3/09, 1/19/09  
Office note 1/6/09  
Operative report 1/15/09  
Visit note 1/15/08, 12/10/08, 12/2/08  
Carrier position documents  
ODG Guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient suffered a calcaneus fracture with open reduction, internal fixation and implantation of a bone growth stimulator. After healing of the fracture, the patient requested removal of the bone growth stimulator due to local neuritis.

This was apparently performed, but was denied by the carrier as medically unnecessary.

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

I disagree with the decision to deny the requested services. The denial of hardware removal was based on poor documentation of fracture status and healing. The records provided for this review have clinical documentation of radiographs that demonstrate complete healing of the fracture, and documentation of neuritis due to the implant. Hardware removal is medically reasonable and necessary in such a case.

**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
- 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)