Core 400 LLC

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DATE OF REVIEW:
Jun/13/2009
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Purchase bone growth stimulator

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:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
ODG Guidelines and Treatment Guidelines
Prescription, 01/28/09
Office note, Dr, 01/29/09
MRI left ankle, 03/11/09
Office notes, Dr., 03/31/09, 04/02/09, 04/16/09, 05/07/09, 05/15/09
MRI left ankle, 04/09/09
Peer review, Dr. 04/24/09
Letter, Dr. 05/15/09
Peer review, Dr. 05/20/09

PATIENT CLINICAL HISTORY SUMMARY
This is a female with complaints of left ankle pain from xx-xx-xx. The MRI of the left ankle dated 03/11/09 showed bone contusions in the talus and calcaneum, subtle marrow edema in the lateral malleolus, moderate ankle joint effusion, fluid collection along the flexor hallucis longus tendon sheath may be related to effusion. On 03/31/09, Dr. examined the claimant. Dr. noted that the claimant had x-rays done from the emergency room which showed no fracture. The claimant was treated with anti-inflammatory medications and a CAM walker. Dr. evaluated the claimant on 04/02/09 and recommended a MRI. The MRI of the left ankle from 04/09/09 showed bone bruise, microtrabecular fracture, involving the talus and calcaneus, small amount of joint effusion is seen and tenosynovitis changes of the flexor hallus longus tendon was unchanged. Dr. saw the claimant on 04/16/09 and felt that the MRI showed a fracture of the calcaneus and talus of the left foot. A bone growth stimulator and Fosamax were recommended. The claimant was seen again on 05/07/09 and had difficulty ambulating.

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

The evidence based literature suggests that ultrasonic bone growth stimulators can be considered reasonable for individuals who have documented nonunion. In this particular case, this individual has subjective complaints of pain that were originally diagnosed as a bone contusion on an MRI two months after an injury. A subsequent study four weeks later suggested a bone bruise and/or microtrabecular fracture. The study itself did not describe worsening of the previous findings suggesting that these may be simply residual from the original injury.

There is no evidence in the medical records provided for this review to suggest that this is a non-union of a fracture. There is no indication to suggest this fracture which has a high healing rate, would do anything other than go on to uneventful union and there is no indication to suggest that the application of a bone growth stimulator in this setting would either augment the healing process and/or improve the eventual outcome. Thus, the request for bone growth stimulator at three months following the original date of injury would neither be reasonable or medically necessary. The reviewer finds that medical necessity does not exist for Purchase bone growth stimulator.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, chapter ankle

Ultrasound BGS Recommended as an option for non-union of long bone fractures or fresh fractures with significant risk factors. Also, limited studies show that patients who received post-operative low intensity ultrasound following ankle fusion showed a statistically significant faster healing rate on plain radiographs at 9 weeks and CT scan at 12 weeks. A 100% fusion rate was noted. (Coughlin, 2008) (Ishikawa, 2002) (Jones, 2006) (Khan, 2008) (Siska, 2008) (Strauss, 1998) See the Knee Chapter for specific indications

Electrical BGS, ODG- Recommended as an option for non-union of long bone fractures. (Petrisor, 2005) See the Knee Chapter for specific indications

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)