

SENT VIA EMAIL OR FAX ON
Mar/19/2009

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/18/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

DME, Bone Growth Stimulator

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

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

OD Guidelines

X-rays 11/04/08

ER note 11/04/08

Office note Dr. 11/07/08, 12/12/08, 01/09/09, 02/06/09

PAC note 11/14/08, 01/26/09

CT 01/29/09

02/10/09, 02/24/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a smoking history injured on xx/xx/xx1/04/08 when he sustained an open comminuted fracture of the shaft of the tibia. He was treated with irrigation and debridement followed by non weight bearing in a boot. On 11/14/08 X-rays showed healing fracture.

On 12/12/08 Dr. noted the wound was nearly healed and x-rays showed a healing fracture. The boot was continued. The claimant was seen on 01/26/09 by the PAC. The claimant reported he had hit his leg on stairs and had pain. On examination he had pain over the mid shaft. There was lucency at the fracture site with a longitudinal line visible on the lateral view.

A 01/29/09 CT documented periosteal endosteal callus with solid periosteal bridging along the posterior margin. Bridging was present along the intermedullary cavity. The entire fracture had not completely fused.

The claimant was seen on 02/06/09 by Dr. who indicated that a bone growth stimulator had been requested at the previous visit. Dr. reviewed the CT scan and recommended continuation of the boot and he also recommended the bone growth stimulator.

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

Review of the records provided would support that at two and one half months post injury, the claimant reported pain at the fracture site, and x-rays showed a lucency on 01/26/09. A CT scan showed incomplete osseous union on 01/29/09, and a bone growth stimulator was ordered.

Based solely on review of the records provided and evidence-based medicine including ODG guidelines, the Reviewer cannot recommend the bone growth stimulator as medically necessary. It does not appear that there is a nonunion separated by 1 cm. It was ordered less than 90 days from the time of the original injury and x-rays have shown indeed progressive healing with callus.

Official Disability Guidelines Treatment in Worker's Comp 2009 Knee and Leg

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)