

SENT VIA EMAIL OR FAX ON  
May/18/2009

# Independent Resolutions Inc.

An Independent Review Organization  
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**DATE OF REVIEW:**  
May/18/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
DME Purchase: Osteogenic Stimulator Left Distel Fibula

**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  
Office note, ,12/22/08, 12/29/08, 01/06/09, 01/19/09  
RTW note, 12/22/08  
MRI left ankle, 01/14/09  
Office notes, Dr., 01/29/09, 02/19/09, 03/05/09  
Review, Dr., 02/24/09  
Office notes, Dr. 03/11/09, 03/12/09, 03/26/09, 03/27/09, 04/09/09  
Letter of Medical Necessity, 03/12/09  
Review, Dr. 03/20/09  
Review, Dr. 04/22/09  
Note from WC adjuster, 01/12/09  
Note from WC Specialist, 03/25/09  
Note from Dr. to claimant, 04/09/09  
Independent Review Organization Summary, 05/01/09  
Encounter Form  
History and Physical Reports 1-4  
X-ray view

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female who sustained a broken tibia resulting in an open reduction internal fixation in xxxx. On xx/xx/xx the claimant fell off a ladder and twisted her left ankle. She presented to FNP, on 12/22/08 for left lateral ankle pain aggravated by physical activity. She

was noted to be a non-smoker. A sprain/strain of the ankle was diagnosed. Medications, an ankle walker and modified work duty were recommended. On 12/29/08 an air cast was recommended. An MRI of the left ankle on 01/14/09 was a limited exam due to artifact from orthopedic hardware within the distal tibia and/or fibula. There were tibiotalar and subtalar ankle effusions, mild tibialis posterior tenosynovitis, no visible ligament or tendon tears and an inferior calcaneal spur suggesting that the claimant had suffered from plantar fasciitis in the past.

Dr. began seeing the claimant on 01/29/09 for continued pain, decreased and painful motion and started the claimant on therapy and recommended continuation of the boot. After continued symptoms without improvement, the claimant was referred to Dr. orthopedic surgeon who saw the claimant on 03/11/09. He indicated that the claimant had treated with a fracture walker for about 4-5 weeks, therapy and anti-inflammatories. The claimant reported continued discomfort on the lateral side of fibula just above the level of the mortis and a new lump in that area. There was pain in the left ankle that was not there before. The examination noted good motion of the left ankle, tenderness over the anterior aspect of the ankle and anterolateral aspect of the ankle as well as tenderness over the subcutaneous border of her fibula over the distal fibula. X-rays of the left ankle that day showed widening of the medial clear space and a residual deformity of the distal tibia from her prior open reduction internal fixation. There was about a 14-degree valgus ankle and mortis. It is evident that she suffered a fibular fracture at the level of the tibial fracture in 2000, both of which are well healed. There appeared to be a new fracture of the fibula approximately 3 ½ centimeters below the original. Left ankle trauma that was inversion injury, possible sprain of anterior inferior tibiofibular ligament or intra-articular problems secondary to the sprain with left fibular fracture were diagnosed. She was to get her prior x-rays and get back in the fracture walker.

The claimant was re-evaluated on 03/12/09 at which time she her x-rays from 12/22/08 were reviewed showing no fracture in the fibula where she currently had a fracture. Dr. stated that the initial fracture was missed on plain x-rays or it was an incomplete fracture that had gradually become more evident with time or that there was a subsequent stress fracture. The claimant was casted and a bone growth stimulator prescribed for a left distal fibular nonunion. The request was denied on two reviews; 03/20/09 and 04/22/09. Dr. stated that the claimant confirmed she had no history between the time she had the work injury and the time he had first seen her. Dr. saw the claimant on 04/09/09 and was better with a lot less discomfort in the lateral side of the ankle. There was a little swelling and tenderness around the fracture itself. X-rays showed progressive healing as expected.

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

Osteogenic bone stimulator of the left distal fibula is not medically indicated and appropriate. The medical records reflect that this is initially a missed fracture and likely a stress reaction, which has become more apparent on radiographs on 03/11/09. There is a previous injury that was noted and an adjacent fracture, medial clear space widening. Given the medial clear space widening and lack of progression of healing in spite of conservative measures, it would not be indicated to oxygenic. Other conservative care should be attempted, as recommended by the ODG.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates, (i.e. Foot/Ankle and Knee Chapters –Electrical Bone Growth Stimulators)

#### **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)