



Notice of Independent Review Decision

DATE OF REVIEW: 9/30/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for Exogen Bone Healing System (E0760).

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

Texas licensed 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)

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.

The previously denied request for Determine the appropriateness of the previously denied request for Exogen Bone Healing System (E0760).

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice of Utilization Review Findings dated 9/15/09.

- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 9/15/09.
- Request for a Review by an Independent Review Organization dated 9/13/09.
- Cover Letter dated 9/16/09.
- Contents Sheet dated 9/16/09.
- Insurance Company's Utilization Review Findings Letter dated 9/9/09, 8/24/09.
- Follow-Up Note dated 9/8/09, 8/5/09.
- Medical Necessity Letter dated 8/27/09.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx

Gender: Female

Date of Injury: xx/xx/xx

Mechanism of Injury: sustained a tibial fracture.

Diagnosis: Stress fracture of the tibia.

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

The claimant is a female- seen on xx/xx/xxxx, for pain in the shin that had been present a week and had started without injury. On examination, there was tenderness and swelling of the tibia. X-rays reportedly showed a stress fracture of the tibia. The physician recommended rest and an Exogen bone growth stimulator to accelerate healing. The bone growth stimulator cannot be recommended as necessary. The claimant accelerated healing has been a focus in this case. These records do not support that the claimant had a co-morbidity that might slow healing. There is certainly nothing to suggest that she would not respond to standard conservative methods for treatment of a tibial stress fracture. The records do not provide sufficient information that would indicate this claimant would fall outside the ODG Knee and Leg recommendations that state that bone growth stimulators can be used for: "(1) Diabetes; (2) Osteoporosis; (3) Steroid therapy; (4) Currently smoking; (5) Fractures associated with extensive soft tissue or vascular damage....Obesity, nutritional or hormonal deficiency, age, low activity level, anemia, infection, or comminuted or other especially complicated fractures" and "in patients with nonunion of bones, excluding the skull and vertebrae, when all of the following criteria are met: (1) At least three months have elapsed since the date of fracture and the initiation of conventional fracture treatments; (2) Serial x-rays have confirmed that no progressive signs of healing have occurred; (3) The fracture gap is one centimeter or less; & (4) fracture is adequately immobilized."

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
- X** ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.
Official Disability Guidelines (ODG), 2009, Knee and Leg - Bone growth stimulators, ultrasound
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).