

SENT VIA EMAIL OR FAX ON
Sep/24/2009

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/17/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Ultrasound Bone Growth Stimulator

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

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in Pain Management

Subspecialty Board Certified in Electrodiagnostic Medicine

Residency Training PMR and ORTHOPAEDIC SURGERY

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

Denial Letters 8/17/09 and 8/26/09

CT Lower EXT Rt 7/28/09

MRI's 4/27/09 and 4/24/09

Dr. 7/6/09

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured on xx/xx/xx. A pipe crushed his foot. He sustained a comminuted non-displaced tarsal navicular fracture. The CT on 7/28/09 showed delayed union of the anterior cortex of the mid portion of the navicular. The medial cuneiform healed.

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

The discussion of the bone stimulator in the foot and ankle section would discourage its use. Yet, in the leg section it discusses its use for long bones, the skull and vertebrae. The criteria it establishes for the use of the stimulator involves 1) documentation of failed treatment over 3 months. This is supplied. 2) Serial radiographs of failure to heal. Again, the MRI and CT scans show this. The gap must be less than 1 cm. A gap of 1cm in the foot would be large.

The serial radiology reports nondisplaced fractures, so this criteria is met. The last criterion is that the fracture be adequately immobilized. The most recent note from Dr. is dated 7/6/09. He wrote about weaning the man from the CAM boot and using shoes and PT. This would not be immobilization. Dr. obviously made comments after the 7/28/09 CT scan requesting the stimulator. These were not provided. They may have better described the immobilization. However, without this information, the Reviewer must rely on the records reducing immobilization. This does not meet the ODG requirements for the device. Dr. may have this information in the record not provided.

ODG--Bone growth stimulators, ultrasound

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)