# I-Decisions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Apr/08/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Bone Growth Stimulator E0747

**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**
Operative report, 12/20/08
Office notes, Dr.: 12/30/09, 3/1/10, 8/26/09, 1/26/09, 9/29/09, 2/16/09, 6/1/09, 8/26/09
Dr., appeal letter, 1/11/10
Peer review reports: 1/7/10, 2/10/10
Certificate of medical necessity, 3/11/10
Prescription for External Bone Stimulator, 12/30/09
EBI form
Pathology Report, 12/24/08
Miscellaneous Office Forms, Dr. dated 1/26/09, 2/9/09, and 3/1/10
MRI left knee, 2/9/09
Operative report, 4/10/09
Prescription for shoe lift, 3/1/10
ODG - Criteria for the use of non-invasive electrical bone growth stimulators

**PATIENT CLINICAL HISTORY SUMMARY**
The claimant is a male. The claimant underwent a open reduction internal fixation of a left hip peritrochanteric fractured femur, which was characterized as displaced and angulated. The operative note indicates that cerclage cables were used to initially reduce and hold the fracture while the guidewire and the intramedullary rod were introduced. The hip screw was then put in place, and the distal locking screw was inserted. Review of the operative note did not reveal any intraoperative complications. At eight months postop on 08/26/09, the claimant presented indicating that he was walking well with his walker at work and around town. The claimant also used the cane at home without significant pain in his left hip. Physical examination revealed that claimant had functional range of motion of the hip with a well healed incisional scar. There is no indication of any pain on hip range of motion or on

ambulation. An x-ray revealed that the implant is in good position. However, it is reported that “unfortunately, there is no evidence of any new callus formation at the peritrochanteric femur fracture site.” The assessment is that the claimant is clinically healing well from his fractured hip, but it is again reported that unfortunately, the x-rays do not demonstrate any new callous formation at the fracture site. Of note is the fact that there is no description of a delayed union or a nonunion or any difficulty with the hardware to substantiate the potential developing of a delayed union or a nonunion.

Specifically, there is no discussion with respect to a gap at the fracture site, a change in the position of the fracture fragments, or complications with the hardware such as loosening or bending.

At one year postoperative on xx/xx/xx, the claimant’s physical exam again demonstrates a well healed incisional scar with good functional range of motion of the hip and a gait that demonstrates a slight abductor lurch. There is no indication that claimant is having any difficulty with pain or any sign of a progressive problem with his fracture in terms of non healing, delayed healing or difficulty with his hardware. An x-ray review on that date is interpreted as postoperative nonunion; it is also stated that bridging callus formation is seen on the lateral view. Again, there is no indication of a complication at the fracture site or a problem with the hardware.

The claimant’s evaluation on 03/01/10 reveals again a stable clinical picture, and an x-ray showing bridging callous formation on the lateral view along with a note of postoperative nonunion. There is no descriptive terminology used in the records presented that would lead one to conclude that the claimant has a problem such as a delayed union or a nonunion or any difficulty with his hardware.

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

ODG criteria for the use of noninvasive electrical bone growth stimulator require that for the use of bone growth stimulator that the bone be stable at both ends by means of cast or fixation and that the two portions of bone involved in a nonunion are separated by less than 1 centimeter. The records show the claimant’s favorable clinical presentation throughout his followup up through 03/01/10 with apparently pain free functional range of motion of the hip and satisfactory ambulatory status with a cane. There is no appropriate description of a delayed union or a nonunion or a description of any difficulty with the hardware bending or loosening. There is a recent x-ray report that indicates bridging callous formation on the lateral view. Based on these records, the request for bone growth stimulator does not satisfy the ODG. The reviewer finds that medical necessity does not exist for Bone Growth Stimulator E0747.

ODG, Criteria for the use of non-invasive electrical bone growth stimulators

Non-union of long bone fracture (5-10% exhibit signs of delayed or impaired healing) must meet ALL of the following

- The two portions of the bone involved in the non-union are separated by less than one centimeter; AND

- Location in the appendicular skeleton (the appendicular skeleton includes the bones of the shoulder girdle, upper extremities, pelvis, and lower extremities); AND

- The bone is stable at both ends by means of a cast or fixation; AND

- A minimum of 90 days has elapsed from the time of the original fracture and serial radiographs over three months show no progressive signs of healing (except in cases where the bone is infected, and the 90-day waiting period would not be required)

(Saxena, 2005) (BlueCross BlueShield, 2007) (BlueCross BlueShield, 2008)

**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)**