

SENT VIA EMAIL OR FAX ON
Jul/13/2010

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/13/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bone Growth Stimulator Right Wrist

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 5/20/10 and 6/15/10
7/1/10
Dr. 5/13/10 thru 6/15/10
OP Reports 5/6/10 and 5/3/10

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured on xx/xx/xx when he fell from a ladder and sustained a fracture of the navicular bone with a perilunate dislocation. . He underwent an ORIF on 5/3/10. An ultrasound bone stimulator was requested.

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

The request is for an ultrasound bone stimulator. The ODG describes indication for long bone fractures with slow or delayed union. The navicular fracture is a small bone fracture with a high incidence of non-union and necrosis, even with a surgical repair. Often a late wrist fusion or insert (arthroplasty) becomes necessary. The ODG discusses a non-displaced navicular fracture. The perilunate dislocation complicated this man's fracture. There was no specific indication or contraindication to the use of the stimulator in the ODG. The information cited by Ms Taylor in her appeal is for generalized fracture care. Considering the type of fracture and the non-union rate, the use of the stimulator is medically necessary. The ODG prefaces notes that individualized care must also be considered.

“ These publications are guidelines, not inflexible proscriptions, and they should not be used as sole evidence for an absolute standard of care. Guidelines can assist clinicians in making decisions for specific conditions and also help payors make reimbursement determinations, but they cannot take into account the uniqueness of each patient's clinical circumstances. “

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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