

SENT VIA EMAIL OR FAX ON
Feb/26/2010

Applied Resolutions LLC

An Independent Review Organization
1124 N Fielder Rd, #179
Arlington, TX 76012
Phone: (512) 772-1863
Fax: (512) 853-4329
Email: manager@applied-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Feb/18/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Purchase of Bone Stimulator

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Doctor of Medicine (M.D.)
Board Certified in 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 11/24/09 and 12/10/09
FOL 2/12/10
Dr. 11/10/09 thru 2/2/10

PATIENT CLINICAL HISTORY SUMMARY

The patient suffered a non-displaced greater tuberosity fracture 3 months ago. The patient has been treated with immobilization and use of an EBI bone growth stimulator. The most recent note from the orthopedic surgeon is physician assistant the fracture is healing. He performed an ultrasound scan shows that the rotator cuff is partially torn. The ultrasound examination as well as radiographic examination demonstrated evidence of bone healing. A request for purchase of a bone growth stimulator has been denied by the insurance

company. Previous requests for authorization of this device were prior to 90 days from the date of injury.

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

Although currently the patient is more than 90 days from the injury and the patient was followed by use of a bone growth stimulator, the medical records provided did not definitively make the diagnosis of non-union. The last note recommended a CT. Based on the current medical records and information known about this patient's shoulder, a bone growth stimulator is not medically feasible or necessary until further review of the CT scan.

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)