

SENT VIA EMAIL OR FAX ON  
Sep/24/2010

## P-IRO Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/24/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

External Electrical 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 with expertise in pain management, wound management and geriatrics. Medical Director of Rehabilitation.

**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 8/9/10 and 8/19/10

Hospital District 6/1/10 thru 7/22/10

Medical Institute 8/2/10

**PATIENT CLINICAL HISTORY SUMMARY**

This claimant is and was involved in a work accident leading to injury to the right fingers. Her required ORIF of the 2nd, 3rd and 4th phalnges and 3rd metacarpal and skin grafts. Imaging shows poor callous formation. However this does not meet the ODG defined guideline for nonunion as there is not evidence on imaging of the amount of separation of the bone.

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

See above. Therefore, based on the ODG listed below, the request is not medically necessary.

ODG 2010 edition

Chapter forearm, wrist and hand

Bone growth stimulators, electrical

.....bone stimulators are used routinely for delayed unions and non-unions but not indicated for treatment of acute fractures or stress fractures.

**non-union must include the two portions of the bone involved in nonunion are separated by less than 5 millimeters** and the bone is stable at both ends by means

of a case or fixation and a minimum of 90 days has elapsed since the time of the original fracture.

**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)