SENT VIA EMAIL OR FAX ON
Sep/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:
Sep/09/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Ultrasound bone Growth Stimulator Rt Tibia Rt Ankle

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)
[X] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 7/8/10 and 6/9/10 Smith & Nephew 8/10/10 Medical Center 2/1/10 thru 6/2/10 University 5/25/10 thru 8/10/10

PATIENT CLINICAL HISTORY SUMMARY
This man sustained a crush injury on xx/xx/xx. It was associated with an open tibial fracture and bimalleolar fracture. He had to undergo a thrombectomy of the tibial artery a couple of days later. A prior reviewer denied the bone stimulator stating the patient was still in dynamization and he did not know the gap size. Dr. wrote on 8/10/10 that the dynamization was stopped 2 months earlier and that the space is 2-3mm between the bone edges.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
This man is 8 months post injury. He is at risk of a nonunion that could lead to repeat surgery and possible amputation. The ODG notes the indications for its use are with soft tissue loss or vascular damage. Both were apparently present. Further, there has been no evidence of any healing on the x-rays. Dr. noted that the ODG requires the gap to me 1mm or less. The gap described here is 2-3mm. By strict criteria, this would exclude the person from receiving the stimulator. On the other hand, it is non invasive and would prove to be cost effective as well as clinically effective if it leads to healing. The request is medically necessary.

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)