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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/31/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Bone growth stimulator purchase only

A 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:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that the request for the bone growth stimulator purchase only is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes dated 02/01/13 – 05/09/13
Operative report dated 01/11/13
Designated doctor exam dated 02/19/13
Therapy notes dated 03/04/13 – 05/28/13
Previous utilization reviews dated 05/17/13 & 06/20/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his right tibia. The operative report dated 01/11/13 details the patient undergoing an open reduction internal fixation for a right tibial fracture. The clinical note dated 02/01/13 details the patient having undergone x-rays which revealed a comminuted and displaced intraarticular distal tibia fracture as well as fibular shaft fracture. The note details the patient having undergone an ORIF at the right tibia as well as a fasciotomy on 01/11/13. The note details the patient undergoing subsequent x-rays which revealed the ORIF at the right ankle. No displacement was noted. The patient was noted to be doing well postoperatively. The patient's pain was being controlled well. The clinical note dated 03/26/13 details the patient stating the initial injury occurred when he fell off a ladder and injured the right ankle. The initial x-rays revealed a comminuted and displaced fracture. Subsequent x-rays taken on this date revealed the plate and screws noted to be in good position. No complications or displacement of the hardware was noted. The clinical note dated 04/11/13 details the patient having undergone an x-ray with minimal evidence of bone healing. The clinical note dated 04/22/13 details the patient rating his pain as 2/10 at the right lower extremity. The note does detail the patient utilizing Flexeril and Hydrocodone for ongoing pain relief. No tenderness was noted upon palpation in the right lower extremity. Edema was present. No instability was noted at any of the joints. The patient was able to demonstrate normal range of motion.

The clinical note dated 05/09/13 details the patient having undergone x-rays which revealed minimal evidence of bone healing. The therapy note dated 05/28/13 revealed the patient having completed 37 physical therapy sessions to date.

The previous utilization review dated 05/17/13 for the purchase of a bone growth stimulator resulted in a denial as no evidence was made available regarding a nonunion separated by less than 1cm and a lack of radiographs over the previous 3 months showing no progressive signs of healing.

The previous utilization review dated 06/20/13 for a bone growth stimulator purchase resulted in a denial as no information was made available for a fracture gap of less than 1cm.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient having undergone an ORIF at the right distal tibia. A bone growth stimulator would be indicated provided the patient meets specific criteria to include serial x-rays confirm no progressive signs of healing and the fracture gap is noted to be less than 1cm. There is a lack of confirmation regarding the patient's fracture gap noted to be less than 1cm. Given that no information was submitted confirming the patient's fracture gap of less than 1cm, this request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for the bone growth stimulator purchase only is not recommended as 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

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)