

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Feb/25/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Purchase of Bone Growth Stimulator for the Left Tibial/Fibula

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Wound assessments dated 11/21/13

Clinical documentation that is unable to be reviewed due to poor copy quality

History and physical report dated 11/01/13

Consultation report dated 11/01/13

Radiographs of the left tibia and fibula dated 11/12/13

Radiographs of the left tibia and fibula dated 12/03/13

Radiographs of the left tibia and fibula dated 12/19/13

Clinical report dated 01/13/14

Radiographs of the left tibia and fibula dated 01/23/14

Utilization review reports dated 12/17/13 & 01/10/14

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx when the left lower extremity was crushed by an object that fell from an unknown height. The patient was assessed with a severe left tibia and fibula fracture which required placement of external fixation. The patient was noted to have had a 1 pack per day smoking history; however, the patient did stop smoking after the accident. Serial radiographs of the left tibia and fibula identified some surrounding sclerosis suggesting an element of bony healing at the left tibia and fibula fractures. As of 12/03/13, radiographs did not show complete healing of the proximal tibial metaphysis. Radiographs from 12/19/13 showed no progressive evidence of healing by formation of additional callus. No bony union was suggested on this study. There was no apparent gap between the fractured segments on this study. The patient was seen on 01/13/14. The patient was felt not to have had healing of the previously placed bone graft. Physical examination identified no pertinent findings. Radiographs of the left tibia and fibula

taken on 01/23/14 showed disused osteopenia of the left knee. There was no further formation of a callous noted.

The requested bone growth stimulator was denied by utilization review on 12/17/13 as there was limited documentation regarding persistent nonunion.

The request was again denied by utilization review on 01/10/14 as there was no documentation regarding radiographs or CT scans indicating a nonunion of the fracture.

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

The patient sustained a substantial injury to the left lower extremity which resulted in severe fractures to the left tibia and fibula and required external fixation. The patient also underwent bone grafting for delayed nonunion of the fracture site in the left lower extremity. Based on review of the most recent radiographs of the left lower extremity, there continues to be a persistent nonunion with absence of callous formation at the fracture site. Per guidelines, the use of bone growth stimulators are indicated in the treatment of long bone fracture nonunion when there is evidence of persistent nonunion on serial radiographs after a minimum of 90 days has elapsed from the date of injury. In this case, the patient has a persistent nonunion for more than 6 months despite multiple surgical attempts including fixation and grafting. As imaging continues to show persistent nonunion at the fracture site, it is this reviewer's opinion that medical necessity in this case is established. Therefore, the prior denials are overturned.

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)