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DATE OF REVIEW: June 1, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Removal of Osteochondritis Dissecans with possible bone graft iliac crest, and osteotomy (29892).

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

Diplomate, American Board of 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

Medical records from the Carrier include:

- 09/02/06, 09/26/06, 10/20/06, 12/18/06,
- D.O., 10/27/06, 11/17/06, 11/03/06,
- M.D., 11/09/06, 11/17/06,
- M.D., 12/14/06,
- Specialists, M.D., 12/18/06,

Medical records from the URA include:

- M.D., undated, 03/28/07, 04/18/07

Medical records from the Requestor include:

- M.D., 12/14/06, 02/27/07, 03/28/07
- D.O., 03/15/07,

PATIENT CLINICAL HISTORY:

The patient is a male who sustained an injury to the right ankle when he twisted his ankle while at work.

The patient was initially treated by, D.O. scan was ordered which revealed an OCD lesion with sclerotic margins. The physical examination by Dr. indicated that there was tenderness to palpation diffusely with no evidence of instability.

The patient was referred to M.D. by D.C. The report given to Dr. was that his ankle popped while at work and that he had persistent pain. Dr. noted no signs of instability or crepitus with normal strength and minor loss of motion.

A required medical examination was subsequently ordered. The required medical examiner, M.D., gives a history that the patient was utilizing a lever bar and felt a pop in his ankle. He went to the local emergency room. X-rays were normal. His note indicates that the patient was placed in a for over 17 weeks. A CT scan was performed on xx/xx/xx, approximately five weeks post injury. Dr. notes that the CT scan indicated a sclerotic old-appearing lesion. Dr. felt that the patient did not require surgery for the compensable injury.

A designated doctor opined that the patient had not reached maximum medical improvement. The diagnosis came to include reflex sympathetic dystrophy.

A lumbar epidural steroid injection was performed by, D.O. on xx/xx/xx.

Surgery was subsequently recommended by, M.D., and was declined by the carrier based upon a peer review. Dr. physical examination of the ankle indicates that the patient walks with a limp, and there was normal texture of the skin. There was no ecchymosis with mild swelling and allodynia was present.

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

It is my opinion, based upon review of the records and the available clinical examination, that surgery is not indicated. The osteochondritis dissecans lesion appears chronic on the CT scan and does not appear in any way related to the compensable injury. In fact, there is no clear evidence that a compensable injury has occurred. This patient felt a pop while at work and this may have been due to an old unrelated injury. There is no evidence that the patient sustained any structural damage to his body from any work event. Additionally, given the presence of what appears to be complex regional pain syndrome, surgery in my opinion is contraindicated. Therefore, I will uphold the decision of the peer reviewer's that removal of the osteochondritis dissecans with possible bone graft and osteotomy is not appropriate and is not related to the compensable injury. This opinion is based upon my education, training, and experience, as well as the Official Disability Guidelines.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)