Independent Resolutions Inc.

835 E. Lamar Blvd. #394
Phone: 817-235-1979
Fax: 817-5489-0310

DATE OF REVIEW: MAY 29, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
OUT PATIENT DECOMPRESSION OF MEDIAL LATERAL PLANTAR NERVES, DECOMPRESTION DEEP PERONEAL RIGHT FOOT.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Provider, board certified in American Board of Podiatric 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
IRO Assignment from TDI, denial letters and correspondence from Carrier/URA, medical records from: Dr. including, History and Physical (2/27/07), PSSD test (2/27/07), Re-evaluation (3/1/07), Letter from Patient (4/9/07), Progress Notes (3/7/07 until 4/27/07); Associates (3/19/07); MRI (9/17/04); Medical Records (2/6/07 and 2/8/07); Medical Records from Dr. (12/13/06); and Medical Records from Dr. (5/17/06 until 2/23/07).

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female with long-standing history of foot pain. Previous to the injury sustained on xx/xx/xx, the patient had been treated by no fewer than three podiatrists for recalcitrant bilateral heel pain. This condition was addressed by plantar fasciotomy on 5/26/06. While left foot symptoms resolved, the right foot continued to experience sharp pain of the inferior heel, similar to her pre-operative symptoms. MRI performed on 9/27/06 revealed a ganglion cyst of the lateral right foot and a fat herniation through the fascia of the abductor hallucis at the medial right foot. The herniated fat and ganglion were excised on 10/19/06. The post-operative course was benign and the patient was pain-free and released to work within three weeks.

On xx/xx/xx, an inmate stomped and kicked the patient's right foot, causing severe pain and difficulty walking. Along with sharp pain at the previous surgery site, the patient experienced pain, numbness, and tingling along the dorsum of the foot into the great toe. A neurology consultation with NCV and EMG revealed decreased peroneal motor amplitudes and otherwise normal findings. The patient began physical therapy but continued to suffer from severe hypersensitivity along the dorsal and medial foot.

On February 27, 2007, the patient received a second opinion evaluation which included Pressure Specified Sensory Device testing. Evidence of sensory impairment was noted along the nerves of the medial, dorsal, and lateral right foot. A second neurology consult was significant for sensory loss on the dorsum of the right foot and an antalgic gait. The EMG and NCV study was normal.

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

The patient complains of severe numbness, tingling, and sharp burning pain along the dorsal and medial aspect of her right foot. At the time of this review, these symptoms have persisted x 6 ½ months despite oral anti-inflammatory medications, activity modification, orthopedic bracing, corticosteroid injections, and physical therapy.

Nerve decompression is a viable option for compression neuropathy, as has been well documented for use in Morton's neuroma and tarsal tunnel syndromes. While the patient does have a history of lumbar surgery, two neurology consultations have found no evidence of radiculopathy and the patient has no complaints of shooting pains down the limb. Low back and hip pain would be expected as the patient has been limping for the six months.

Although the initial NCV and EMG study found only mild pathology, these tests are affected by temperature, distance measurement, interexaminer variability, and demographic considerations like age, gender, and height. PSSD has demonstrated both sensitivity and specificity in identifying and measuring peripheral neuropathy. {Soomekh D. Quantitative sensory testing. Clin Podiatr Med Surg. 2006 Jul;23(3):545-57.}

The deep peroneal nerve is susceptible to compression neuropathy in a crush injury due to the anatomical considerations of the area. Specifically, there is a relatively thin layer of soft tissue through which the deep peroneal nerve can pass on the dorsal foot. With regard to the medial and lateral plantar nerves, the patient has had not one but two previous surgeries in that anatomic location. The latter surgery involved a soft tissue mass near the abductor hallucis muscle, a well-known location for nerve entrapment. It is reasonable to assume that at only 3 weeks post-op, a blunt blow to the foot could lead to nerve entrapment in scar tissue where two previous surgeries had been performed. In addition, a recent study has demonstrated how an ankle sprain can lead to compression of he medial and lateral plantar nerves. {Pessure changes in the medial and lateral plantar and tarsal tunnels related to ankle position: a cadaver study. Foot Ankle Int. 2007 Feb;28(2):250-4.}

In summary, the patient has continued to experience sharp tingling, burning, and pain along the dorsal and medial aspect of her right foot x months following her injury. Objective findings note positive Tinel's sign, antalgic gait, sensory loss, and persisting edema with color changes. It is reasonable to conclude that the injury resulted in nerve compression of the dorsal and medial right foot. Therefore, decompression of the deep peroneal and medial and lateral plantar nerves would constitute a sound treatment plan where a beneficial outcome could be reasonably expected.

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)**
    - Pessure changes in the medial and lateral plantar and tarsal tunnels related to ankle position: a cadaver study. Foot Ankle Int. 2007 Feb;28(2):250-4.}
    - Soomekh D. Quantitative sensory testing. Clin Podiatr Med Surg. 2006 Jul;23(3):545-57