



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 12/14/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under dispute include a foot insert molding and orthopedic footwear.

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

The reviewer is a board certified orthopedic surgeon (medical doctor) who has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination in all its parts.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Dr. and

These records consist of the following (duplicate records are only listed from one source): Dr. : 6/17/02 to 10/22/08 progress notes, IR report by Dr. dated 2/3/03, Initial medical report by Dr. 5/28/02, 9/28/01 and 10/20/06 lumbar MRI reports and 1/8/03 report by , PT.

: adverse determination letter of 10/7/08, preauth request of 9/29/08, script 9/18/08, reconsideration request of 10/30/08 and LMN of 10/22/08.

We did not receive a copy of the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case regards a xx year old male with an on the job injury resulting in lumbar pain and given diagnosis of lumbar disc displacement, and spondylosis without myelopathy. The request for prospective medical necessity determination for foot insert molding and orthopedic footwear is at dispute.

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

According to the ODG, this treatment is recommended as an option for patients with a significant leg length discrepancy or who stand for prolonged periods of time. Not recommended for prevention. This Cochrane review concluded that there is strong evidence that insoles are not effective for the prevention of back pain, but the current evidence on insoles as treatment for low-back pain does not allow any conclusions. (Sahar-Cochrane, 2007) They may be helpful for patients with a significant leg length discrepancy (> 2-3cm) or with prolonged walking requirements. Shoe insoles (or inserts) are devices placed inside shoes that may vary from over-the-counter foam or rubber inserts to custom-made orthotics. One of the therapeutic objectives of shoe inserts is the reduction of back pain. Shoe lifts (or heel lifts) are additions made to the heel or sole of a shoe to increase its height. The therapeutic objective of shoe lifts is to compensate for lower limb length inequality and thereby reduce back pain. Shoe insoles may be effective for patients with acute low back problems who stand for prolonged periods of time. Given the low cost and low potential for harms, shoe insoles are a treatment option. Shoe lifts may not be appropriate for treatment of acute low back problems when lower limb length difference is <=2 cm.

Custom molded longitudinal/metatarsal arch supports and orthopedic footwear are not supported by the ODG for treatment of spondylosis or lumbar disc displacement. Because this case is chronic and a leg length difference is not indicated, this DME is not medically necessary at this time according to the records provided.

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)