

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 10, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right ankle arthrodesis take down with total ankle replacement, subtalar joint arthrodesis, gastrocnemius recession, application hemocyte, posterior splint, pain pump with two night stay.

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

MD, 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 or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for Right ankle arthrodesis take down with total ankle replacement, subtalar joint arthrodesis, gastrocnemius recession, application hemocyte, posterior splint, pain pump with two night stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 10/10/08, 10/31/08

ODG Guidelines and Treatment Guidelines

MD report, 05/28/04

Office note, Dr., 08/11/08

Office note, Dr., 09/19/08
Office notes, Unknown provider, 09/25/08, 10/21/08
Letter from Dr., 10/03/08
Office note, Dr., 10/17/08
CT lower extremity x 2, 09/30/08
Pre auth request form, 10/03/08
Letter / Academy foot and ankle specialists, 10/23/08
Patient history form, 09/24/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old female claimant who reportedly has undergone numerous surgeries to the right ankle. The records indicated that the claimant underwent a right ankle arthroscopy on 10/05/01 and was noted to have superolateral talar dome osteochondral defect treated with debridement of synovitis and lateral gutter impingement lesion. The claimant reportedly continued to be symptomatic with increased pain. A repeat arthroscopy with decompression of the talar dome osteochondritis dissecans with microfracture followed in 2002. The records indicated that the claimant did return to work with the development of more ankle pain. An osteochondral autograft of the right ankle subsequently followed in February 2003. Continued difficulty with right ankle motion was reported. An open capsulotomy with debridement was performed on 09/12/03 with noted fibrous ankylosis of the joint. Due to continued chronic ankle pain, the claimant subsequently underwent a right ankle tibiotalar fusion on 02/18/04. Medical records of 2008 document that the claimant reported right ankle pain, popping and swelling. A non union of the lateral gutter post ankle fusion and subtalar joint arthrosis was diagnosed. Additional surgery in the form of a right ankle revision arthrodesis take down with total ankle replacement was recommended.

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

Request was multifactorial and included a request for right ankle arthrodesis take down with a total ankle replacement, subtalar joint fusion, gastrocnemius resection, and application of hemosite, posterior splint, pain pump, and two day length of stay. Per ODG Guidelines, total ankle replacement is deemed not recommended. It is felt to be investigational. The extent of conservative treatment was not outlined. Therefore, in accordance with ODG Guidelines, a total ankle arthroplasty is not deemed indicated thus nor would the application of positioner splint, pain pump, and two day length of stay. The reviewer finds that medical necessity does not exist for Right ankle arthrodesis take down with total ankle replacement, subtalar joint arthrodesis, gastrocnemius recession, application hemocyte, posterior splint, pain pump with two night stay.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Ankle and Foot:

ODG Indications for Surgery™ -- Ankle Fusion: Arthroplasty (total ankle replacement

ODG Indications for Surgery™ -- Ankle Fusion:

Criteria for fusion (ankle, tarsal, metatarsal) to treat non- or malunion of a fracture, or traumatic arthritis secondary to on-the-job injury to the affected joint:

1. Conservative Care: Immobilization, which may include: Casting, bracing, shoe modification, or other orthotics. OR Anti-inflammatory medications. PLUS:

2. Subjective Clinical Findings: Pain including that which is aggravated by activity and weight-bearing. AND Relieved by Xylocaine injection. PLUS:

3. Objective Clinical Findings: Malalignment. AND Decreased range of motion. PLUS:

4. Imaging Clinical Findings: Positive x-ray confirming presence of: Loss of articular cartilage (arthritis). OR Bone deformity (hypertrophic spurring, sclerosis). OR Non- or malunion of a fracture. Supportive

imaging could include: Bone scan (for arthritis only) to confirm localization. OR Magnetic Resonance Imaging (MRI). OR Tomography.

Procedures Not supported: Intertarsal or subtalar fusion.

Arthroplasty (total ankle replacement)- Not recommended.

Total ankle replacement has been investigated since the 1970s with initially promising results, but the procedure was essentially abandoned in the 1980s due to a high long-term failure rate, both in terms of pain control and improved function. Currently, four ankle prostheses are commercially available or under investigation in the U.S. The main alternative to total ankle replacement is arthrodesis. While both procedures are designed to reduce pain, the total ankle replacement is additionally intended to improve function. At the present time there are inadequate data on available total ankle replacements to permit conclusions regarding their safety and effectiveness.

Milliman Care Guidelines. Inpatient and Surgical Care 12th Edition.
Orthopedic Knowledge Update, 9, Vaccaro, editor Chapter 21 p. 265- 267 .

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)**

Orthopedic Knowledge Update, 9, Vaccaro, editor Chapter 21 p. 265- 267 .

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)