

I-Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: MARCH 11, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

AFO Brace & Work Boots/ steel toe and steel shank in toe

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 1/31/08, 1/2/08

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

MD, 1/16/08, 1/8/08, 12/7/07, 11/2/07, 10/12/07, 2/15/08

Rehabilitation Center, 1/11/08, 11/13/07

Operative Report, 9/29/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a patient who sustained a fracture six months ago who underwent surgical treatment for it and has done extremely well from the procedures. He does not have a foot drop, and has been offered light-duty employment.

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

The criteria used in this analysis included the ODG in TWC, Ankle. An AFO is recommended as an option for foot drop. It is used during surgical or neurological recovery. In this case, the patient does not have a foot drop, and hence, an AFO is not recommended. At six months post-injury with a heeled surgical correction, immobilization or the work boot type treatment does not offer support and there is no evidence in the medical records of ankle instability. It is not clear what the medical indication is for the requested ankle foot orthosis or the steel shank, steel toe work boot. In this case, this person who underwent a low ankle ORIF on 9/29/07, who has continued to follow and improve without any indication of neurological deficit or deterioration or instability, there is no medical justification within the medical records for this recommendation. For these reasons, the previous denials are upheld.

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)**