

# Applied Assessments LLC

*An Independent Review Organization*  
1124 N. Fielder Road, #179, Arlington, TX 76012  
(512) 772-1863 (phone)  
(512) 857-1245 (fax)

## Notice of Independent Review Decision

**DATE OF REVIEW:** March 21, 2008

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Triple Arthrodesis of left foot

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

M.D., Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in Pain Management  
Subspecialty Board Certified in Electrodiagnostic Medicine  
Residency Training PMR and 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)

Upon independent review the reviewer finds that the requested Triple Arthrodesis of the left foot is medically necessary.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters 2/4/08, 3/5/08  
ODG Guidelines and Treatment Guidelines  
Surgery Orders 1/25/08  
Office Visits 11/26/07, 11/25/07, 2/18/08, 1/25/08, 10/26/08, 3/10/08  
Carrier Submission Letter 3/12/08

Evaluation 11/6/06  
Pre-Op Orders and Op Report 11/6/02  
Follow-Up Office Note 1/28/05  
Prescription 4/28/06  
Office Visit 7/5/06  
WC Status Reports 9/6/06, 11/29/06, 1/25/08, 7/2/07, 10/26/07, 2/18/08  
Office Visits 9/6/06, 11/29/06, 7/2/07, 7/27/07, 12/28/06, 4/28/06  
Progress Note 12/15/06

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This man sustained bilateral calcaneal fractures in a fall from a ladder. He underwent surgery to stabilize the fractures. He had a left and right subtalar fusion for late arthritis in 1998. This procedure is noted in the ODG as necessary in poor outcomes of treatment of calcaneal fractures. ( Surgery for calcaneal fractures...Recommended....There also was a trend for nonoperatively treated patients to have a higher risk of experiencing severe foot pain than did operatively treated patients..... However, those who were treated nonoperatively were significantly more likely to require late subtalar arthrodesis. ([Dooley, 2004](#))). . He went on to have more left than right foot pain. He was found to have symptomatic arthritis in the mid foot with a nonunion of the left subtalar fusion and arthritic changes at the ankle joint. Dr. performed an IME in 2006 and concurred that a triple arthrodesis is appropriate. There are no specific xrays provided, but the narrative reports from the treating doctors and the IME provider describe arthritis in the ankle, talocalcaneal, calcaneocuboid and talonavicular joints. He had transient relief with lidocaine injection into the joints.

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

The purpose of a triple arthrodesis is the relief of pain for an arthritic foot with unstable joints. It involves the fusion of the talocalcaneal, talonavicular and calcaneocuboid joints. This is a major operation with a prolonged recovery period and often some significant morbidity.

Recommended as indicated below. Also see [Surgery for calcaneal fractures](#).

### **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.

Triple arthrodesis of the left foot is medically necessary for this patient. He has more than a decade of management of the pain with conservative care including NSAIDS. The

records describe increased pain relief with xylocaine injections. The records described decreased and painful ranges of motion. Specifics malalignment was suggested in the descriptions of arthritis and loss of the angle of declination. The narrative descriptions of the xrays both by the treating surgeon and IME physician described the nonunion, arthritis, spurs, etc. on xray and CT scan.

**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)**