



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 5/8/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an open tenosynovectomy.

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 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 regarding the prospective medical necessity of an open tenosynovectomy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Foot & Ankle Center – DPM

These records consist of the following (duplicate records are only listed from one source): Records reviewed from, DPM: Work Comp Patient Registration Form-2/29/08; Office Notes-3/10/08 - 3/24/08; Diagnostic Health MRI report-12/28/07; Dr. office notes-10/23/07 - 12/14/07.

Records reviewed: preauthorization denial-3/28/08 & 4/8/08.

WC Network Treatment Guidelines were not received for the purposes of this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female injured at work when an approximately 50 lb suitcase fell onto her left foot. She sustained a 4th metatarsal fracture which healed given conservative care. Presently she complains of persistent pain, worse with walking, better with rest for 7 months. Cortisone injections have provided no benefit.

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

The ODG does not apply in this case as the procedure is not listed for diagnosis provided. Based on the clinical information provided and the MRI, there is no indication for the requested procedure to be considered medically necessary. No objective findings are noted and symptoms appear by description to be purely subjective. Therefore, this procedure is not approved at this time based upon the documentation provided. A search of several guideline websites (including pubmed.gov) did not reveal any indications for this procedure

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)**