

Notice of Independent Review Decision

Date of Review: 05-27-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left ankle debridement, tenosynovectomy with possible tendon transfer

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

Certified by The American Board of 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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	726.72	28086 28200 29761 28300	Upheld

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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Non-Certification of Service/Procedure dated, 04-09-08
Non-Certification of Service/Procedure (Upheld) dated, 04-23-08
Accident/Injury Information Form
Worker's Compensation Information Sheet
MRI of the left ankle dated, 01-04-08
Medical notes dated, 02-01-08, 02-28-08
Official Disability Guidelines (ODG) – none provided

PATIENT CLINICAL HISTORY:

This xx-year-old claimant's injury occurred on xx/xx/xx when the claimant slipped and fell and injured the left foot and ankle. MRI dated 01-04-08 showed several subchondral cysts. The medical note of 02-01-08 indicated the original injury was to the knee and shoulder and the claimant presented with ankle complaints. The complaint was bone rubbing against bone sensation. There were the diagnoses of left tibial tendonitis and synovitis. The ankle and foot were immobilized.

The follow-up visit on 02-28-08 noted no improvement in the complaints of foot pain. The physical examination was unchanged. Surgical intervention was suggested to include a Dwyer Calcaneal osteotomy. The request for preauthorization and reconsideration were not certified and considered not medically necessary.

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

Based on the clinical data presented for review, the Reviewer determined that there is no clinical indication for these procedures. The MRI reports cystic changes and these would not require surgical intervention. The reported tendonitis is "suggested" and that would not require surgical intervention. There is no documentation of any conservative measures other than immobilization, and thus, the standards outlined by the ODG are not met. The osteotomy is addressing a varus deformity and there are no documented clinical findings of acute pathology to warrant such a surgical intervention. In the opinion of the Reviewer, there is no medical evidence to support the medical necessity of the requested procedures.

**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)