



Medical Review Institute of America, Inc.
America's External Review Network

Amended Review 04/14/09

DATE OF REVIEW: April 13, 2009

IRO Case #:

Description of the services in dispute:

This is a request for DME Custom molded long, Arch Support x 2 #L3010, 2 pair 10-15mmhg Comp Hose A6549 Custom molded AFO #L1970, and 2 soft interfaces for BK section #L2820.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is board certified by the American Board of Orthopaedic Surgery. This reviewer is a member of the American Academy of Orthopaedic Surgeons and the Society of Military Orthopaedic Surgeons. This reviewer has been in active practice since 2005.

Review Outcome

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: Upheld

Based on ODG Guidelines, the request for the DME Custom molded long, Arch Support x 2 #L3010, 2 pair 10-15mmhg Comp Hose A6549 Custom molded AFO #L1970, and 2 soft interfaces for BK section #L2820 is not medically necessary.

Information provided to the IRO for review

Records Received from the State:

Confirmation of receipt of a request for a review by an IRO (4 pages)

Request form, Request for a review by an IRO (3 pages)

Letter dated 03/02/09 (4 pages)

Letter dated 03/12/09 (4 pages)

Records Received from Insurance Company:

ODG Guidelines, TWC/ankle (2 pages)

MD clinic note dated 06/10/08, 06/24/08, 07/01/08, 07/16/08, 08/26/08, 09/16/08, 09/23/08,

2875 S. Decker Lake Drive Salt Lake City, UT 84119 / PO Box 25547 Salt Lake City, UT 84125-0547

(801) 261-3003 (800) 654-2422 FAX (801) 261-3189

www.mrioa.com A URAC & NCQA Accredited Company

10/22/08, 11/12/08

Medical Center, operative report dated 06/16/08 (2 pages)

Health Services, MD, PA, clinic note dated 01/30/09, 02/25/09, 03/02/09, 03/03/09, 03/06/09, and 03/12/09.

Records Received from Office of Insured Employee Counsel:

Prescription from Dr. dated 02/17/09 (1 page)

Prescription from Consultants, INC dated 01/31/09 (1 page)

Patient clinical history [summary]

The patient is a female who sustained a right trimalleolar ankle fracture on xx/xx/xx after falling while roller skating . She was treated with open reduction internal fixation on 6/16/08. Post operatively she was placed in a walking boot and kept nonweightbearing. She was allowed to perform ankle range of motion. She began progressive weight bearing in the brace around 6 weeks post op. At two months post op she was walking with a cane and had improving range of motion. At three months post op she attempted to transition to a high top shoe and her motion showed 5 degree dorsiflexion and 30 degrees plantarflexion. She had difficulty without the brace so kept using it. She still had some restricted motion and tenderness but x-rays shows good healing of her fractures. She was eventually able to transition to a regular shoe but still had ankle pain and some tenderness over prominent hardware. Her surgeon discussed possibly removing the hardware as otherwise the ankle appeared to be healing well.

The patient was seen by Dr. on 1/30/09 for continuing pain and inability to perform activities, pain from her hip to her ankle with weakness in her leg. His exam reports no asymmetry, crepitus, swelling, or effusion. There was tenderness of the medial malleolus and medial plantar region, intact sensation, motion showed extension 5 degrees flexion 45 degrees. X-rays report well reduced bimalleolar ankle fracture. He recommended treatment with NSAIDS, physical therapy, home exercises, selective medial plantar foot injections, arch supports, an ankle orthosis, TED hose, and light duty for her post operative condition and a diagnosis of plantar fasciitis. She followed up a month later with complaints of pain, spasms, stiffness, and tingling of the right ankle. He recommended continuing the same treatment plan and that she take time off work. Her symptoms were unchanged at the next several office visits.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The patient was prescribed custom mold long arch supports for a presumed diagnosis of plantar fasciitis, however there are no subjective complaints (morning heel pain that improves with walking and stretching) or exam findings (tenderness of plantar fascia with pain on there on dorsiflexion stretching) to support this diagnosis. In addition there is no described deformity that would

warrant a custom molded arch support in place of an off the shelf support. Plus there is limited support for the arch support in the ODG foot and ankle chapter:

"As part of the initial treatment of proximal plantar fasciitis, when used in conjunction with a stretching program, a prefabricated shoe insert is more likely to produce improvement in symptoms than a custom polypropylene orthotic device or stretching alone. The percentages improved in each group were: (1) silicone insert, 95%; (2) rubber insert, 88%; (3) felt insert, 81%; (4) Achilles tendon and plantar fascia stretching only, 72%; and (5) custom orthosis, 68%. (Pfeffer, 1999)

Orthotic devices: Under study for plantar fasciitis. Recommended for foot pain in rheumatoid arthritis. Orthoses should be cautiously prescribed in treating plantar heel pain for those patients who stand for long periods; stretching exercises and heel pads are associated with better outcomes than custom made orthoses in people who stand for more than eight hours per day. (Crawford, 2003)"

Thus, custom mold arch supports are not medically necessary.

Regarding the request for an ankle foot orthosis (AFO) with soft interfaces, it is unclear why this was prescribed. AFO are often used in the treatment of foot drop to assist in gait. It can also be used to stabilize the ankle. This patient has no history of foot drop or ankle instability. The ODG only recommends an AFO for a foot drop, "Ankle foot orthosis (AFO), Recommended as an option for foot drop. An ankle foot orthosis (AFO) also is used during surgical or neurologic recovery. The specific purpose of an AFO is to provide toe dorsiflexion during the swing phase, medial and/or lateral stability at the ankle during stance, and, if necessary, push-off stimulation during the late stance phase. An AFO is helpful only if the foot can achieve plantigrade position when standing. Any equinus contracture prohibits its successful use. The most commonly used AFO in foot drop is constructed of polypropylene and inserts into a shoe. If it is trimmed to fit anterior to the malleoli, it provides rigid immobilization. This is used when ankle instability or spasticity is problematic, such as in patients with upper motor neuron diseases or stroke. If the AFO fits posterior to the malleoli (posterior leaf spring type), plantar flexion at heel strike is allowed, and push-off returns the foot to neutral for the swing phase. This provides dorsiflexion assistance in instances of flaccid or mild spastic equinovarus deformity. A shoe-clasp orthosis that attaches directly to the heel counter of the shoe also may be used. (Geboers, 2002)"

Finally the compression TED hose were requested for the patients complaint of leg swelling, however the notes do not document any significant swelling or edema. The patient has no described history of peripheral vascular disease or a history of DVT, and she is at minimal risk for a post op DVT this far out from surgery. It is common for patient with ankle fractures to have continued swelling for many months after surgery, however in order to indicate them in this case there needs to be better documentation of the swelling on the exam.

A description and the source of the screening criteria or other clinical basis used to make the decision:

ODG foot and ankle chapter

Pfeffer G, Bacchetti P, Deland J, Lewis A, Anderson R, Davis W, Alvarez R, Brodsky J, Cooper P, Frey C, Herrick R, Myerson M, Sammarco J, Janecki C, Ross S, Bowman M, Smith R. Comparison of custom and prefabricated orthoses in the initial treatment of proximal plantar fasciitis. *Foot Ankle Int.* 1999 Apr;20(4): 214–21.

Geboers JF, Drost MR, Spaans F, Kuipers H, Seelen HA. Immediate and long-term effects of ankle-foot orthosis on muscle activity during walking: a randomized study of patients with unilateral foot drop. *Arch Phys Med Rehabil* 2002 Feb;83(2): 240–5.