I-Resolutions Inc.

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DATE OF REVIEW:
Apr/01/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient right foot/ankle tarsal tunnel release, bio arch arthrodesis, neurosleeve augmentation repair and removal of ganglion cyst

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., board certified in Orthopedic Surgery

REVIEW OUTCOME:

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

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY
This is an injured worker with a previous history of a tarsal tunnel release in xxxx with apparently no reported benefit. Apparently a chair rolled over her foot resulting in complaints of pain in the distribution of the tarsal tunnel area. Current requested treatment is for repeat tarsal tunnel release with a Bio-Arch arthrodesis, neural sleeve augmentation and repair, and removal of a ganglion cyst.

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

The reviewer concurs with the previous reviewer that the outcome of recurrent tarsal tunnel surgery based on the ODG Guidelines is poor at best. The operative report documents that there has been adequate release of all the potential branches that may be causing symptoms. The patient's failure to improve after the previous surgery does not bode well for successful surgery in this particular instance. The medical records do not give this reviewer any guidance as to why this patient would benefit from this procedure and why the ODG Guidelines should be set aside. Other providers who have physically examined the patient have not recommended any further intervention. The request does not meet the guidelines. The reviewer finds that medical necessity does not exist for Outpatient right foot/ankle tarsal tunnel release, bio arch arthrodesis, neurosleeve augmentation repair and removal of ganglion cyst.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)