

Notice of Independent Review Decision  
**CORRECTED REPORT**  
**Reviewer specialty omitted from initial report.**  
**Date of initial report omitted from page 2.**

Initial Report: August 5, 2009  
 Corrected Report: August 6, 2009

**DATE OF REVIEW:** 08/03/09

**IRO CASE #:**

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

Osteotomy of the second metatarsal, left foot

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

D.P.M., Board Certified, practicing in the State of Texas for 20+ years

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
250.60			<i>Prosp.</i>						<i>Upheld</i>
705.15	28308		<i>Prosp.</i>						<i>Upheld</i>

**INFORMATION PROVIDED FOR REVIEW:**

1. Letters of denial dated 07/07/09 and 06/11/09
2. Peer Review report dated 06/03/09
3. Correspondence from internist dated 06/13/09
4. Office visits dated 06/13/07 through 05/20/08
5. Adjustor's letter dated 06/06/08
6. Designated Doctor Evaluation dated 01/05/09
7. Laboratory reports dated 06/13/07, 09/06/07, and 03/05/08
8. Records from May 2008 hospitalization

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The patient is a neuropathic diabetic male who developed a sore, ulceration, cellulitis, hospitalization, and underwent hallux amputation, following a work-related injury. That is the end of the time line as far as specific documentation for his foot wounds and pathology.

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

The reason the review was upheld has to do with limited documentation as to the pathophysiology and prior treatment options offered to this patient to include palliative measures to include periodic wound care, off-loading total contact inserts, etc. Insufficient clinical information was provided to support the reversal of the denial of this procedure based on ODG Guidelines.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- \_\_\_\_\_Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)