



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Notice of Independent Review Decision

DATE OF REVIEW: 11/05/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right triple arthrodesis and bone graft of the right heel/ankle

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

Board Certified in Orthopedic Surgery
Board Certified in Foot and Ankle Surgery
Fellowship Trained in Orthopedic Trauma

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Right triple arthrodesis and bone graft of the right heel/ankle - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

CT scan of the right calcaneus interpreted by M.D. dated 01/22/09
Evaluations with M.D. dated 07/30/09, 08/27/09, 09/17/09, and 10/15/09
A Utilization Review Referral note from Dr. dated 09/90/09
A letter of non-certification, according to the Official Disability Guidelines (ODG),
from M.D., dated 09/14/09
A letter of non-certification, according to the ODG, from M.D., dated 10/01/09
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

The CT scan of the right calcaneus interpreted by Dr. on 01/22/09 showed a partially healed markedly comminuted complex intrarticular fracture of the calcaneus. On 08/27/09, Dr. recommended a subtalar fusion or triple arthrodesis. He also felt the patient was not at Maximum Medical Improvement (MMI) at that time. On 09/14/09, Dr. wrote a letter of non-certification for a right triple arthrodesis and bone graft. On 10/01/09, Dr. also wrote a letter of non-certification for the surgery. On 10/15/09, Dr. again recommended the surgery.

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

There is no substantiation of evidence on a clinical basis for fusion, i.e. marked tenderness over the talonavicular joint or the calcaneal cuboid joint. Also, more preferably would be CT scan evidence of significant arthritis/arthrosis of these additional Chopart joints. Without substantiation that there are significant changes to these joints, I do not believe that fusion should be required. It should also be noted there will be a greater degree of stiffness in the area following fusion in addition to the stiffness that already exists. Furthermore, the ODG does not support the use of arthrodesis for subtalar fusion. Therefore, the requested triple arthrodesis and bone graft of the right heel/ankle is neither reasonable nor necessary. The previous adverse determinations should be upheld.

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)