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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/25/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
4 Custom Molded Longitudinal Metatarsal Arch Support and 4 Ladies Depth Inlay Orthopedic Shoes

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified in Physical Medicine and Rehabilitation

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
Official Disability Guidelines; Angle and Foot Orthotic Devices
Denial Letters, 7/2/10, 7/15/10
Patient Letter, 8/5/10
Photographs, 7/11/10
Medical Center 8/4/10, 7/16/10, 7/8/10
Medical Center 10/9/09, 2/17/10
Occupational Health Systems 7/20/10
Injury 1 2/3/10
FCE 2/3/10
Progress Note 10/8/07 to 8/4/10
7/2/10, 7/15/10
West 6/28/10, 6/29/10
Office Visit Note 9/2/09

PATIENT CLINICAL HISTORY SUMMARY
This woman sustained a right ankle injury on xx/xx/xx. She apparently had a medial malleolar fracture and degloving injury. She had a skin graft. She was described as having keloids laterally and posteriorly about the right ankle. There is a loss of dorsiflexion and inversion and eversion. There is a limp and slow speed. She wrote that she has balance problems from the foot and the orthosis would improve her gait. Dr. performed an IME on 7/20/10 and described the keloids. He found callosities on the right 2nd and 3rd metatarsals. He noted she was wearing inserts in both shoes. He also noted she wore a right sided AFO. He wrote that "It would be reasonable for her to have the inserts replaced when they wear out approximately every 6 months. She will also need some shoes to assist her in support of the feet and ankles along with her shoe inserts. "

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
The ODG describes the use of orthoses for plantar fascitis and for metatarsalgia. The

photographs reviewed showed the presence of a right arch. I did not have a left foot for comparison. While there are many who believe everyone would benefit from arch supports, they are generally utilized to redistribute the stresses on the feet (plantar fascitis and metatarsalgia). I did not see that these conditions were described in the records.

The patient reports feeling unbalanced, but there was no objective evidence. The reduced gait velocity is most likely associated with the reduced ankle motion and would not be improved with a shoe insert. Dr. noted she had a shoe insert, but did not describe this as an arch support, orthotic, heel pad, etc. I did not find in the records documentation of the medical necessity for the metatarsal arch support requested. While some use heel inserts or orthotics to control hyperpronation of the hind foot, this patient was reported as having reduced eversion. The request does not satisfy the ODG guidelines. The reviewer finds that medical necessity does not exist for 4 Custom Molded Longitudinal Metatarsal Arch Support and 4 Ladies Depth Inlay Orthopedic Shoes.

Orthotic device

Under study for plantar fasciitis. Recommended for foot pain in rheumatoid arthritis. See also Prostheses (artificial limb). 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) 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) Evidence indicates mechanical treatment with taping and orthoses to be more effective than either anti-inflammatory or accommodative modalities in the treatment of plantar fasciitis. (Lynch, 1998) (Gross, 2002) For ankle sprains, the use of an elastic bandage has fewer complications than taping but appears to be associated with a slower return to work, and more reported instability than a semi-rigid ankle support. Lace-up ankle support appears effective in reducing swelling in the short-term compared with semi-rigid ankle support, elastic bandage and tape. (Kerkhoffs, 2002) For hallux valgus the evidence suggests that orthoses and night splints do not appear to be any more beneficial in improving outcomes than no treatment. (Ferrari-Cochrane, 2004) Semirigid foot orthotics appear to be more effective than supportive shoes worn alone or worn with soft orthoses for metatarsalgia. (Chalmers, 2000) The use of shock absorbing inserts in footwear probably reduces the incidence of stress fractures. There is insufficient evidence to determine the best design of such inserts but comfort and tolerability should be considered. Rehabilitation after tibial stress fracture may be aided by the use of pneumatic bracing but more evidence is required to confirm this. (Rome-Cochrane, 2005) Foot orthoses produce small short-term benefits in function and may also produce small reductions in pain for people with plantar fasciitis, but they do not have long-term beneficial effects compared with a sham device. The customized and prefabricated orthoses used in this trial have similar effectiveness in the treatment of plantar fasciitis. (Landorf, 2006) Eleven trials involving 1332 participants were included in this meta-analysis: five trials evaluated custom-made foot orthoses for plantar fasciitis (691 participants); three for foot pain in rheumatoid arthritis (231 participants); and one for hallux valgus (209 participants). Custom-made foot orthoses were effective for rearfoot pain in rheumatoid arthritis (NNT:4) and painful hallux valgus (NNT:6); however, surgery was even more effective for hallux valgus. It is unclear if custom-made foot orthoses were effective for plantar fasciitis or metatarsophalangeal joint pain in rheumatoid arthritis. (Hawke, 2008) Rocker profile shoes are commonly prescribed based on theoretical considerations with minimal scientific study and validation. Rocker profiles are used to afford pressure relief for the plantar surface of the foot, to limit the need for sagittal plane motion in the joints of the foot and to alter gait kinetics and kinematics in proximal joints. In this review, efficacy has not been demonstrated. The effectiveness of rocker-soled shoes in restricting sagittal plane motion in individual joints of the foot is unclear. Rocker profiles have minimal effect on the kinetics and kinematics of the more proximal joints of the lower limb, but more significant effects are seen at the ankle.

(Hutchins, 2009) Outcomes from using a custom orthosis are highly variable and dependent on the skill of the fabricator and the material used.
A trial of a prefabricated orthosis is recommended in the acute phase, but due to diverse anatomical differences many patients will require a custom orthosis for long-term pain control. A pre-fab orthosis may be made of softer material more appropriate in the acute phase, but it may break down with use whereas a custom semi-rigid orthosis may work better over the long term. See also Ankle foot orthosis (AFO).

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)

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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