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## Notice of Independent Review Decision

**DATE OF REVIEW:** 08/23/10

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a subtalar arthrodesis.

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

The reviewer is a Medical Doctor who is board certified in Orthopedics. The reviewer has been practicing for greater than 10 years.

### **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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a subtalar arthrodesis.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

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These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: office notes 12/9/09 to 6/25/10, 12/9/09 left ankle radiographic report and 6/17/10 left ankle MRI report.

: 8/5/10 letter by, 7/6/10 denial letter, 7/9/10 reconsideration information letter, 7/19/10 denial letter, 7/2/10 report by MRloA, 7/9/10 report by MRloA, 7/1/10 and 7/8/10 preauth request forms and 7/7/10 letter by MD.

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant has been documented to have ongoing pain post ankle arthroscopy and subsequent ankle joint fusion. The original mechanism of injury involved a twisting-loading ankle injury. Objective/imaging findings (from 6/17/10) have been reported as talar bone edema with articular surface (cortical irregularity) at the talocalcaneal joint. Non-operative treatment reportedly has failed and the claimant has been considered for a talocalcaneal fusion. Provider records did not reveal any evidence of complex regional pain syndrome and only reflected the expected lack of motion at the ankle joint itself. The claimant reported "good pain relief" for several days post injection of the affected area.

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

Despite the days of pain relief from one injection at the sub-talar joint, the subjective, exam and imaging studies have not reflected a diagnosis of arthrosis-arthritis of the subtalar/talocalcaneal joint. Delineation of localized tenderness, swelling and joint space irregularities (of the subtalar joint) have not occurred. There have been no objective findings compatible with that diagnosis. There has been a lack of evidence that comprehensive non-operative treatment has been attempted and failed. Without adequate delineation of the exact ongoing pain generator(s), and, with relatively minimal attempts at a comprehensive non-op. program (including multiple different types of braces, orthotics, medications, one injection, therapy etc.), the considered procedure is not reasonably required.

Reference: ODGuidelines

ODG Indications for Surgery™ -- Ankle Fusion:

Criteria for fusion (ankle, tarsal, metatarsal) to treat non- or malunion of a fracture, or traumatic arthritis secondary to on-the-job injury to the affected joint:

1. Conservative Care: Immobilization, which may include: Casting, bracing, shoe modification, or other orthotics. OR Anti-inflammatory medications. PLUS:
2. Subjective Clinical Findings: Pain including that which is aggravated by activity and weight-bearing. AND Relieved by Xylocaine injection. PLUS:
3. Objective Clinical Findings: Malalignment. AND Decreased range of motion. PLUS:
4. Imaging Clinical Findings: Positive x-ray confirming presence of: Loss of articular cartilage (arthritis). OR Bone deformity (hypertrophic spurring, sclerosis). OR Non- or malunion of a fracture. Supportive imaging could include: Bone scan (for arthritis only) to confirm localization. OR Magnetic Resonance Imaging (MRI). OR Tomography.

Procedures Not supported: Intertarsal or subtalar fusion.

**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)