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Notice of Independent Review Decision

DATE OF REVIEW: 01/19/2010

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right AFO and a pair of mis-mate orthopedic shoes

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- 10-21-09 Medical report from Dr.
- 11-04-09 Script for AFO right from Orthopedic Bracing, illegible signature
- 11-16-09 Letter of medical necessity from Orthopedic Bracing
- 11-19-09 Adverse Determination Letter
- 12-02-09 Letter of Medical Necessity from Dr.
- 12-14-09 Reconsideration request
- 12-21-09 Letter of Adverse Determination for appeal,
- 12-19-09 Request for IRO from the provider
- 12-30-09 Confirmation of Receipt of Request for IRO from TDI
- 01-04-10 Notice of Case Assignment for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is an employee who sustained an industrial injury to the right foot on xx/xx/xx. He underwent ORIF for a pilon fracture (comminuted fracture of the distal tibia).

According to a medical note of October 21, 2008 the patient is status post right pilon fracture two years prior after ORIF with malunion/non-union. He is morbidly obese and has bilateral knee osteoarthritis. He is non-weightbearing and is using a motorized wheelchair. There is no edema, the swelling is reduced and has he relatively well preserved ankle motion. Assessment is pilon fracture, nonunion, malunion. Surgery has not been recommended due the edema in his leg. As he has some improvements, he will be sent back for another opinion regarding treatment. The patient will remain non-weightbearing.

On November 4, 2009, request was made for one pair of orthopedic shoes and a right ankle foot orthosis (AFO). According the suppliers invoice of November 16, 2009 the requested orthoses will include: Right solid ankle custom molded AFO ($611.84), right malleolus padding ($59.29), right anterior shell, custom molded ($611.77), right carbon graphite lamination ($310.20), right femoral length fracture sock ($147.08), right and left orthopedic shoes ($232.22) and extra charge for mis-mate sizing ($5.00), total $2027.40.

Request for an AFO and custom shoes was considered in review on November 19, 2009 with recommendation for non-certification with rationale that as the patient will continue with non weightbearing and a wheelchair there is no need for custom orthotics and shoes. Also, the patient already has a walking AFO brace which presumably he does not use as he is non-weightbearing. Additionally, since the patient is noted to have good ankle ROM, using an AFO brace is likely to adversely affect that. A peer discussion was attempted but not realized.

According to a letter of medical necessity dated December 2, 2009 the patient has been followed for two years for a tibial plateau fracture that has not healed. It is the opinion of several specialists that he is not a candidate for nonunion take down to the OVT, the severe lymphadema, his weight and just the appearance of the fracture. It is recommended that he be placed on an ankle-foot orthosis to protect the ankle to allow him to begin mobilizing for transfers. Without this support it is felt that the stressors about his foot and ankle will be excessive.

Reconsideration was also requested from the orthopedic supply company on December 14, 2009.

Request for an AFO and custom shoes was considered in review on December 21, 2009 with recommendation for non-certification. A peer discussion was conducted with the provider. The provider reported the goal is to prevent collapse of the distal tibia as a result of weightbearing during transfers. The patient's distal tibia fracture appears to have progressed to fibrous union or non union. The internal fixation hardware continues to function appropriately. Per the reviewer, the application of the AFO does not meet criteria published in the ODG.

Request has been made for an IRO.

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

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.

The patient is morbidly obese and has a two-year old distal tibia fracture with non-union. The patient will remain non-weightbearing and in a wheelchair. He will also return for another surgical consultation as he has made some improvement in his leg edema which has been preventing a revision surgery.

Orthotics are requested to provide additional support during transfers. A pair of mis-mate orthopedic shoes has also been requested. As the patient will not be walking, the rationale for a pair of orthopedic shoes is lacking. Per a prior review, the patient has a walking AFO brace, which he could use. An AFO brace could adversely affect the patient's ankle ROM which is good at this time. In the future, if a decision is made for a revision surgery and the patient recovers sufficiently for weightbearing, consideration could be warranted for orthoses and orthotic shoes. However, at the present time, the rationale for orthopedic shoes and an AFO brace simply for transfers for a non-weightbearing patient is not clarified and does not appear to be medically necessary.

Therefore, my recommendation is to agree with the previous non-certification for right AFO and a pair of mis-mate orthopedic shoes.

The IRO's decision is consistent with the following guidelines:

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

__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

The Official Disability Guidelines - Foot and Ankle Chapter (12-18-2009) Ankle Foot Orthoses (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.