US Decisions Inc.

An Independent Review Organization
9600 Great Hills Trail, Ste 150 W
Austin, TX 78759
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/08/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left ankle fusion 27870

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon

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

[ ] Upheld (Agree)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY
This is a male with a date of injury of xx/xx/xx after an inversion injury to the left ankle. Dr. began treating the claimant in September 2010. Dr. noted that the left ankle weight bearing x-rays showed a cystic osteochondral lesion of the medial talar dome that appeared to involve 30% of the medial talus, significant spurring of the anterior distal tibia and at the medial gutter but overall the joint space appeared to be reasonably well maintained. Dr. stated that the MRI of the lower extremity from 08/18/10 revealed a large cystic osteochondral lesion of the medial talar dome that involved the medial 50 % of the articular surface and spans nearly the entire AP dimension of the dome of the talus. Dr. stated that there was disruption of the overlying articular cartilage and significant spurring at the anterior ankle and a moderate amount of bone marrow edema at the neck of the calcaneus consistent with stress reaction versus microtrabecular fracture. Dr. has treated the claimant with Medrol dose pack, sedentary duty, walking boot, antiinflammatory medication, light duty without the boot and a 10/06/10 ankle injection. On 10/20/10, the claimant reported temporary relief of the injection.

Dr. saw the claimant on 02/08/11 and recommended an arthrodesis for the diagnosis of osteochondral defect of the talus and degenerative arthritis of the ankle. On 03/02/11, Dr. saw the claimant. Examination revealed standing foot position was PG, mild to moderate swelling, tenderness over the anterior ankle joint, moderate restrictions in range of motion of the ankle and range of motion was painful. There was mild restrictions in subtalar inversion and eversion and instability to drawer testing when compared to the contralateral side. Dr. stated that bracing had been denied. Dr. has recommended an ankle fusion. Review of the peer review from 03/10/11 documented that the claimant has been treated with physical therapy.

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

Left ankle fusion 27870 is medically necessary in this xx-year-old male who has had injection, antiinflammatory, Medrol-Dosepak, brace immobilization, orthoses, activity modification and physical therapy. In spite of these measures, his symptomatology has been persistent. MRI demonstrates the osteochondral lesion of the talar dome of significant portion and degenerative change on radiographic findings. Based on the consistent subjective complaints, objective findings and imaging and failure of appropriate nonoperative care, the reviewer finds that Left ankle fusion 27870 is medically necessary.

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)