

SENT VIA EMAIL OR FAX ON
Jan/24/2011

True Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/21/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

R. Ankle Tibiotalar Joint Injection under Fluoroscopy

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

Board Certified Orthopedic Surgeon (Joint)

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

1. Carrier submission Law office of 01/05/11
2. Radiology imaging report chest, AP portable 03/10/09
3. Radiology imaging report left foot 03/10/09
4. Radiology imaging report right foot 03/11/09
5. Radiology imaging report right foot 03/10/09
6. Operative report removal of 2 syndesmotoc screws from lateral malleolus, M.D. 06/18/09
7. Operative report open reduction internal fixation of lateral fibular fracture, open reduction internal fixation medial malleolus, syndesmotoc ligament reconstruction with syndesmotoc screws, M.D. 03/10/09
8. Appeal letter for authorization for injection to right ankle, 12/20/10
9. Peer-to-peer review M.D. 12/10/10
10. Office visit/progress notes M.D. 08/27/09-11/30/10
11. Utilization review notification of determination re: right ankle tibiotalar steroid injection celestone, Marcaine, hyaluronic acid, M.D. 12/10/10

12. Utilization review notification of determination appeal Right ankle tibiotalar joint injection under fluoroscopy, M.D. 12/30/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is xx/xx/xx. The records reflect that he sustained a crush injury to the right ankle. X-rays of the right ankle revealed an acute displaced medial malleolus fracture and acute comminuted fracture of the distal fibula, with disruption at the tibiotalar joint with lateral subluxation of the talus compared to the tibia and widening and incongruity at the medial tibiotalar joint space. On xx/xx/xx the claimant underwent open reduction internal fixation (ORIF) of lateral fibular fracture with plating, ORIF of the medial malleolus, and syndesmotic ligament reconstruction with syndesmotic screws. He subsequently underwent removal of syndesmotic screws on 06/18/09.

The claimant was noted to be back at work full duty on 09/11/09. He stated that his ankle was still sore but improving, still stiff and feels weak. He continued to complain of lateral ankle pain, and on 12/24/09 he underwent an injection of the tibiotalar joint with 2cc of lidocaine, 2cc of Marcaine and 3cc of Celestone. Progress report dated 01/14/10 noted that the claimant did not experience much relief at all with the injection. The claimant underwent removal of lateral fibular plate and screws as well as two screws over the medial malleolus in 04/10. The patient was released to return to work regular duty and activity as of 05/27/10. On 11/30/10 the patient reported he was still having a lot of aching and soreness in the right ankle especially with cold weather. He continues to work full duty. On physical examination there was some limited plantar and dorsiflexion, some mild tenderness to palpation around the ankle joint itself, but no erythema or signs of any infection. There was slight pain with weight bearing.

A request for intraarticular injection into the right tibiotibular joint was reviewed by Dr. on 12/10/10, and Dr. determined the request to be non-certified as medically necessary. Dr. determined that the documentation submitted did not elaborate into the efficacy of the patient's physical medicine or pharmacological interventions, and no evidence was apparent in the documentation supporting symptoms related to osteoarthritis. Dr. further noted that the patient's functional deficits do not warrant going outside guideline recommendations.

An appeal request was reviewed by Dr. on 12/30/10 and upheld the prior non-certification. Dr. noted that the documentation indicated that the patient underwent a prior ORIF of the right ankle with hardware removal. The patient complains of persistent pain despite physical therapy, medication management, the patient underwent one prior corticosteroid injection on 12/24/09 with no substantial relief in symptoms. Dr. noted that the patient would not warrant a repeat injection given the lack of improvement with the initial injection, and the request was non-certified.

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

Based on the clinical data submitted, the request for right ankle tibiotalar joint injection under fluoroscopy is not indicated as medically necessary. The patient sustained a crush injury to right ankle on xx/xx/xx. He underwent ORIF of medial malleolus fracture and comminuted fracture of the distal fibula, with subsequent removal of hardware. He was able to return to work full duty following surgery and hardware removal. The claimant continued to complain of lateral ankle pain, and an injection of the tibiotalar joint was performed 12/24/09 without significant benefit. The claimant has subjective complaints of pain, but physical exam findings were unremarkable. Official Disability Guidelines provide that injections of the ankle are under study and there is no strong evidence supporting the use of injections in the treatment patients with ankle or foot pain. X-rays did not document osteoarthritis. Given the lack of objective findings, and noting the failure of previous injection to provide any substantial relief, medical necessity is not established for the proposed tibiotalar joint injection.

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

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)