



---

Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax:  
877-738-4395

## Notice of Independent Review Decision

**DATE OF REVIEW:** 03/23/11

**IRO CASE #:**

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

Cryotherapy machine rental for 14 days, new cryo pad, postoperative foot orthosis, CPM machine rental for 21 days, and a new pad for the CPM machine

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

Board Certified in Orthopedic Surgery  
Fellowship Trained in Foot and Ankle Surgery

### **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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Cryotherapy machine rental for 14 days – Upheld  
New cryo pad – Upheld  
Postoperative foot orthosis - Upheld  
CPM machine rental for 21 days – Upheld

A new pad for the CPM machine - Upheld

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

An MRI of the right ankle interpreted by M.D. dated 11/12/10  
Evaluations with D.P.M. dated 12/02/10, 01/13/11, and 02/15/11  
A letter of medical necessity for an ankle/foot orthosis from Dr. dated 01/03/11  
CT scans of the foot and ankle interpreted by M.D. dated 01/07/11  
Letters of medical necessity for cryotherapy and a CPM Machine rental from Dr. dated 01/13/11  
A letter of non-certification, according to the Official Disability Guidelines (ODG), from,, M.D. dated 01/27/11  
A letter of non-certification, according to the ODG, from D.P.M. dated 03/01/11  
A team conference call with Dr. dated 03/01/11  
The ODG Guidelines were not provided by the carrier or the URA

### **PATIENT CLINICAL HISTORY**

An MRI of the right ankle interpreted by Dr. on 11/12/10 showed bone marrow edema and linear lucency most likely representing bone marrow contusion or non-displaced fracture, calcaneal bursitis, fluid in the subtalar joint, and tendinosis. On 12/02/10, Dr. provided premolded inserts and recommended orthotic devices, a night splint, and a Cortisone injection. On 01/03/11, Dr. wrote a letter of medical necessity for a foot/ankle orthosis. CT scans of the foot and ankle interpreted by Dr. on 01/07/11 showed a lateral talar dome osteochondral lesion, advanced middle and posterior subtalar joint osteoarthritis, and mild sclerotic changes of the sesamoids at the first MTP joint. On 01/13/11, Dr. recommended ankle surgery, a CPM machine, and cryotherapy. On 01/27/11, Dr. wrote a letter of non-certification for a cryotherapy unit, cryotherapy pad, CPM machine pad, or postoperative foot orthosis. On 02/15/11, Dr. requested precertification for surgery. On 03/01/11, Dr. also wrote a letter of non-certification for the cryotherapy machine, CPM machine, pads, and the orthosis.

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

The DME being requested is clearly not recommended per the Official Disability Guidelines (ODG), which clearly states that there is no supporting data for a cryotherapy machine rental or a cryo pad, per page 48, in the ODG, especially in regard to comparison to more typical postoperative compression and standard modes of ice, as would be given in most normal circumstances. As far as for the continuous passive motion (CPM) machine, again it is not recommended per the ODG. These items are clearly experimental and have been mostly used in knee

management and do not have any substantial supporting data for their usage in the foot and ankle postoperatively, especially when it comes to continuous passive motion. Therefore, the recommended cryotherapy machine rental for 14 days, a new cryo pad, a postoperative foot orthosis, a CPM machine rental for 21 days, and a new pad for the CPM machine would not be reasonable or necessary and the previous adverse determinations should be upheld at this time.

**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 AND KNOWLEDGE BASE
- 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)**