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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/16/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient right subtalar fusion with two days length of stay

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)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines-Treatment for Workers' Compensation

Utilization review determinations, 10/07/11 and 10/25/11

Emergency department records 07/07/09

Discharge summary 07/24/09

Operative report 07/20/09

Operative report 11/19/10

Clinical records Dr., 2011

Radiographic report right calcaneus 06/20/11

Fluoroscopy report 07/28/11

Designated doctor addendum 09/28/11

MRI lumbar spine 09/15/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained a right calcaneus and lateral malleolus fracture as result of fall from approximately 20 feet. He was admitted to Emergency Department. On xx/xx/xx he underwent ORIF of calcaneus fracture and ORIF of lateral malleolus fracture. He was identified as having painful hardware and was returned to surgery on 11/19/10 at which time he underwent removal of right calcaneus hardware and right distal fibula hardware. Postoperatively, the claimant is reported to have pain, which is controlled by medications. He was seen by, Dr. on 06/20/11. His wounds are well healed. He has no signs of infection. He has about 8 degrees of subtalar motion that is not painful. He has no pain to palpation, no deformity. Radiographs show maintenance of alignment of his fracture. The subtalar space looks well maintained but somewhat congruent. He had subtalar injection, which was performed on 06/28/11. He had 80% pain relief for 5-6 days, and was reportedly quite happy with it. Subtalar fusion was recommended. MRI of lumbar spine dated 09/15/11 shows multilevel degenerative spondylosis without focal disc herniation or

significant acquired central spinal canal stenosis. On 09/19/11 subtalar fusion was recommended.

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

This man sustained a fracture of calcaneus and distal fibula as result of a fall from approximately 20 feet. He underwent ORIF of the calcaneus and distal fibula fractures. He was later identified as having symptomatic hardware, which was subsequently removed. He continued to have right foot pain and underwent diagnostic and therapeutic injection on 07/28/11 with 80% relief for nearly a week. This injection was diagnostic and therapeutic confirming the subtalar joint as source of the man's pain.

Based on totality of the clinical information, the reviewer finds the request for Inpatient right subtalar fusion with two days length of stay is medically necessary and consistent with current evidence based guidelines.

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)