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Notice of Independent Review Decision

Date notice sent to all parties: 10/23/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Removal of bone protrusion in the right foot

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 and Orthopedic Traumatology

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 medical necessity exists for each of the health care services in dispute.

Removal of bone protrusion in the right foot - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Reports from M.D. dated 03/20/07, 03/27/07, 04/03/07, 04/26/07, 05/17/07, 06/28/07, 07/26/07, 08/23/07, 09/18/07, 10/23/07, 11/29/07, 12/27/07, 01/24/08, 02/28/08, 04/03/08, 05/08/08, 07/17/08, 09/18/08, 11/20/08, 01/22/09, 03/12/09, 05/21/09, 08/13/09, 10/15/09, 12/17/09, 02/18/10, 04/15/10, 06/10/10, 08/12/10, 10/14/10, 12/16/10, 02/24/11, 04/21/11, 06/16/11, 08/18/11, 10/13/11, 12/15/11, 02/09/12, 04/05/12, 06/07/12, 08/09/12, and 09/07/12

Operative report from Dr. dated 04/04/07

Prescription from Dr. dated 04/05/12

Notifications of Adverse Determinations from dated 08/24/12 and 10/09/12

The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

On 03/20/07, Dr. noted the patient sustained a complete Lisfranc fracture and had been an insulin dependent diabetic for 10 years. Surgery was recommended and it was noted he might develop Charcot arthropathy. Dr. performed excision of the cuneiforms, as they were completely crushed with the fusion of the midfoot, autologous bone graft, and excision of the medial, immediate, and lateral cuneiform because of severe comminution and poor bone stock on 04/04/07. On 05/17/07, x-rays revealed early healing and good alignment. He would remain off of work. On 06/28/07, x-rays revealed probable signs of early healing. Dr. was somewhat worried about the skin lesion over the mid dorsal aspect of the foot, as well as the second toe. He was placed in a short leg cast. He was doing progressively better on 09/18/07 and x-rays revealed evidence of osteopenic bone, but there was good healing over the midfoot fusion. He was put in a boot and placed on full weightbearing. On 01/24/08, Dr. noted the patient presented for a double upright brace. He had reasonable swelling on examination and it was felt he was developing significant problems within the calcaneus with Charcot fracture arthropathy of the calcaneus. The diagnoses were arthropathy and diabetes with peripheral circulatory disorders. He was given a prescription for a double upright clamshell brace. Vicodin was refilled by Dr. on 05/08/08 and x-rays did not reveal evidence of progressive healing and Charcot arthropathy of the heel. He was advised to take care of his diabetes. On 01/22/09, Dr. noted the patient had some prominence of bone at the undersurface of the foot and mainly over the lateral aspect at the metatarsocuboidal joints. He was in an extra depth shoe and a custom Plastizote insert. The patient wanted protruding bone removed and refill of Vicodin. Dr. noted on 08/13/09 in light of the patient's diabetes, he developed severe Charcot arthropathy whereby he dislocated his cuneiforms.

He was given a new prescription for shoes and a Plastizote insert. On 02/18/10, the patient's work restrictions were sitting six hours per day and standing and walking no more than two hours a day. On 06/10/10, the patient had a slight rocker bottom deformity on examination, but was noted to be coming along overall. Exodeck shoes, longitudinal inserts, and custom inserts were prescribed. Vicodin was refilled. Dr. noted on 02/24/11 that the patient requested a refill of Vicodin and wanted special socks for his diabetes, as well as inserts. On 06/16/11, he was doing well and his present treatment was continued. On 10/13/11, the patient stated he was doing well, but complained of tenderness over the foot. He had a little bit of a rocker deformity over the plantar aspect of the lateral Lisfranc's joint. Additional extra depth shoes and inserts were recommended and Vicodin was refilled. On 04/05/12, Dr. provided the patient with new inserts. On 06/07/12, it was noted the patient had not received extra depth shoes or Plastizote inserts as of late. He had a warm foot on examination and a slight rocker bottom deformity over his foot. The shoes and inserts were felt to be necessary, as to prevent further breakdown. On 08/09/12, Dr. noted the patient had shortening of his medial column and his lateral column was a little bit longer. He also had somewhat of a protrusion of the rocker bottom deformity. X-rays revealed evidence of full healing, but clinically he had a prominent bone with evidence of callus formation of the involved area. Dr. recommended removal of the bone protrusion. On 08/24/12, D.O., on behalf of, provided a notification of adverse determination for the requested bone removal. On 09/07/12, Dr. stated the need for the bone removal was work related and he felt the current clinical condition was related to the original injury and subsequent surgery. On 10/09/12, M.D., also on behalf of, provided another notification of adverse determination for the requested bone removal procedure.

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

Clearly, this is a very difficult issue to deal with as the deformity often becomes progressive and eventually leads to breakdown of the soft tissues above the mechanical process. It appears that Dr. had recommended a Plastizote insert and extra depth shoes and he noted on 06/07/12 that they had not yet been provided. It also does not appear based on the documentation reviewed that Dr. has made any attempts at some form of alternative bracing and I do believe that this should be attempted first before surgical management as there is

a high likelihood that further breakdown will occur with progressive lessening of the weightbearing surface and more concentrated force on the remaining area after resection. The complicating factor for this patient are his long standing diabetes and peripheral circulatory disorder. It is not clear from the documentation reviewed what his current weight is or the current status of his peripheral vascularity. There is also no documentation of failure of conservative treatment, such as physical therapy, activity modifications, or response to medications. There are no real objective deficits documented on the examinations reviewed. Therefore, in my opinion, the requested removal of the bone protrusion in the right foot is not 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 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)**