



# MedHealth Review, Inc.

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## Notice of Independent Review Decision

**DATE NOTICE SENT TO ALL PARTIES:** 6/2/13

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a STAT OP right subtalar joint fusion.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

**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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a STAT OP right subtalar joint fusion.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant sustained a right calcaneal fracture while working on the DOI of xx/xx/xx. The injury mechanism was not denoted. Despite non-operative and then open reduction and internal fixation; the claimant reportedly developed post traumatic arthritis. Clinical notes (including from 4/15/13) discuss persistent antalgic gait, pain, swelling, reduced motion and tenderness at the affected "hindfoot" area. Treatments have included medications, subtalar comminuted intraarticular cortisone injection (that was not associated with significant pain reduction) and along with restricted activities. An 11/12/12 dated right foot CT scan revealed a healed calcaneal fracture. Denial letters denoted the lack of pain relief with injection, immobilization or orthotics trials, lack of significant motion deficit, joint space narrowing and/or misalignment.

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

The claimant has not had recent documentation of extensive trial and failure of comprehensive non-operative guideline criteria such as immobilization and PT. In addition, non-responsiveness to the intraarticular subtalar joint injection also does not meet criteria for the request. Imaging does not reveal significant joint space narrowing indicative of arthritis. Therefore at this time, the applicable ODG clinical guidelines have not been met and the request is not considered reasonable or medically necessary.

Reference: ODG Ankle/Foot Chapter Indications for Surgery- Ankle Fusion: Criteria for fusion (ankle, tarsal, metatarsal) to treat non- or malunion of a fracture, or traumatic arthritis secondary to on-the-job injury to the affected joint:

1. Conservative Care: Immobilization, which may include: Casting, bracing, shoe modification, or other orthotics. OR Anti-inflammatory medications. PLUS:
2. Subjective Clinical Findings: Pain including that which is aggravated by activity and weight-bearing. AND Relieved by Xylocaine injection. PLUS:
3. Objective Clinical Findings: Malalignment. AND Decreased range of motion. PLUS:
4. Imaging Clinical Findings: Positive x-ray confirming presence of: Loss of articular cartilage (arthritis). OR Bone deformity (hypertrophic spurring, sclerosis). OR Non- or malunion of a fracture. Supportive imaging could include: Bone scan

(for arthritis only) to confirm localization. OR Magnetic Resonance Imaging (MRI). OR Tomography.  
Procedures Not supported: Intertarsal or subtalar fusion, except for stage 3 or 4 adult acquired flatfoot.

**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)**