

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 4, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Left Metatarsophalangeal joint injection X 1 (20610), Fluoroscope (76000)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

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)

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee is a female who reported an injury to her left great toe on xx/xx/xxxx. She reported a xx stepped on her toe with his heel.

The injured employee underwent a physical therapy evaluation on xx/xx/xxxx. X-rays were reported negative for fracture or abnormalities. There were subjective complaints of left great toe pain. Upon physical examination, the injured employee's body mass index was 27.99. There was tenderness to palpation to the first metatarsophalangeal joint. The neurovascular examination was normal. The sensory examination was intact. The deep tendon reflexes were symmetric. The clinical assessments were a foot contusion and left great toe pain. The recommendation was for physical therapy. The injured employee then underwent physical therapy.

During an evaluation, there were subjective complaints of left foot pain. The injured employee had been working regular duty. Upon physical examination, the left great toe had swelling with pain when walking and pain with manipulation. The range of motion was within normal limits. The clinical assessments were a foot contusion, great toe pain, and derangement of the joint. The recommendation was for an orthopedic evaluation.

performed an evaluation on November 26, 2014. Upon physical examination, there was tenderness to palpation and osteophyte formation of the left great toe. There was no ecchymosis or swelling.

performed an evaluation on December 23, 2014. There were subjective complaints of left great toe pain. Upon physical examination, there was a normal gait with a closed toe shoe. There was tenderness along the first metatarsophalangeal joint. There was a dorsal osteophyte in this region. There was a slightly limited range of motion due to pain. The alignment was normal. Light touch was intact. X-rays of the left foot reported degenerative changes at the first metatarsophalangeal joint. The recommendation was for Ibuprofen and a first metatarsophalangeal joint steroid injection under radiographic guidance.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

As noted in the peer-reviewed, Division-mandated Official Disability Guidelines Ankle and Foot Chapter, updated December 22, 2014, intra-articular corticosteroid injections are not recommended. Most evidence for the efficacy of intra-articular corticosteroid injections is confined to the knee with few studies considering the joints of foot and ankle. No independent clinical factors have been identified that can predict a better post-injection response. Evidence is limited. Therefore, medical necessity could not be established.

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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA

- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

- MILLIMAN CARE GUIDELINES

- XX 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)