

Applied Resolutions LLC

An Independent Review Organization

Phone Number:
(817) 405-3524

900 N Walnut Creek Suite 100 PMB 290
Mansfield, TX 76063

Fax Number:
(817) 385-9609

Email: appliedresolutions@irosolutions.com

Notice of Independent Review Decision

Case Number:

Date of Notice: 05/06/2016

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Left second Tarsometatarsal Steroid Injection under Radiographic Guidance

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 patient is a female with a reported date of injury of XX/XX/XX when a large X fell on her feet. The patient was subsequently seen at the emergency department diagnosed with a bruise. The patient has been in physical therapy and ambulates with a postoperative shoe. The patient currently utilizes Aleve for pain control. The patient continues to have pain at the dorsal midfoot region and has never had problems with this foot prior to the injury. On XX/XX/XX, the patient was seen complaining of left foot pain. On examination, the physician indicated the patient was in no acute distress and ambulated with an antalgic gait in the postoperative shoe. There was tenderness and swelling at the dorsal aspect of the midfoot region near the second and third tarsometatarsal joint. The physician referenced an MRI done on XX/XX/XX revealing an unremarkable examination. The physician took in office x-rays revealing no evidence of fracture, lesion, or other osseous abnormality. The physician recommended a CT scan of the foot and a followup appointment. The request was made for a Left second Tarsometatarsal Steroid Injection under Radiographic Guidance.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The patient is a female who underwent a crushing injury on XX/XX/XX to her feet and continues to have pain in the left foot. The patient has undergone numerous imaging studies which are primarily unremarkable as well as physical therapy treatment. The requested Left second Tarsometatarsal Steroid Injection under Radiographic Guidance is not recommended as guidelines indicate intra-articular corticosteroids have limited evidence for efficacy with few studies considering the joints in the foot and ankle. Given that, at this time, the guidelines do not recommend intra-articular corticosteroid injections for the ankle or foot, the requested Left second Tarsometatarsal Steroid Injection under Radiographic Guidance would not be medically necessary and the denial remains upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)