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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 01/27/2010

IRO CASE #:

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

This case was reviewed by a Orthopaedic Surgery, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Revision arthroscopy and cheilectomy versus hallux MTP fusion

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturn (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 10-13-08 Operative report, cheilectomy, from Dr.
- o 11-12-08 Operative report, wound dehiscence left foot from Dr.
- o 11-25-08 Medical report from Dr.
- o 09-02-09 Medical report from Dr.
- o 10-26-09 Medical report from Dr. (?) - initial page only
- o 11-11-09 Initial examination from Dr.
- o 11-25-09 Follow up report from Dr.
- o 12-04-09 Initial Adverse Determination Letter from Medinsights and review
- o 12-22-09 Adverse Determination Letter for reconsideration from and review
- o 01-15-10 Attorney letter .

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female employee who sustained an industrial injury to the left foot on xx/xx/xx when hit in the left hallux. Someone opened a door and she suffered fracture of her toe. She wore a post-op shoe followed by a boot. The patient underwent cheilectomy of the first metatarsal phalangeal joint of the left foot on October 13, 2008 for traumatic hallux rigidus.

On November 12, 2008 the patient underwent wound debridement of the left foot for a fairly deep infection. The extensor hallucis longus tendon was found to be intact, but the dorsal capsule along with the extensor hallucis brevis tendon was compromised. The joint surface itself looked very good. She apparently had a recent infection along the nailfold that spread to the surgery site. When seen in follow up on November 25, 2008 the patient had no swelling, warmth or erythema and the incision was completely

healed. She had responded well to antibiotics. The sutures were removed.

The patient was seen in follow up in occupational medicine on September 2, 2009 for a knot on the bottom of her right foot by the heel. She has been walking on her heel and it is too painful to walk normally. She reports a pain level of 7/10. There is swelling and a focus of pain at the medial plantar surface of her heel. She has discomfort at the hallux as well with limited motion. Her treating doctor is holding off on therapy and is requesting the prior surgery procedure notes. She is exquisitely tender in the area of concern and there is swelling at the ankle. She does have full range of motion and full strength. There is tenderness over the entire plantar fascia and toe range of motion is significantly limited. X-rays shows soft tissue edema, otherwise a normal study.

Assessment is contusion of the left hallux, fracture of the left hallux status post surgical repair of the MP joint, RSD of CRPS, plantar fasciitis traumatic and secondary to changing gait due her current condition. Heel cups or heel pads were recommended and continued use of the fracture boot.

Designated Doctor examination and opinions were provided on September 14, 2009 (report not available).

The patient returned to occupational medicine on October 26, 2009. She reports a pain level of 6/10. She has been recommended to either have PT or debridement of the scar tissue on the tendon. She has discontinued Lyrica.

The patient was provided a specialty foot examination on November 11, 2009. She has had foot pain since someone opened a door and she suffered fracture of her toe. She wore a post-op shoe followed by a boot, followed by a hallux cheilectomy on October 13, 2008 complicated by infection, and a wound debridement on November 20, 2008. She rates her pain as 8/10. There is no edema or swelling. Motor strength is full. Sensation is normal. No instability is found. Ankle range of motion is full and pain free. Subtalar and midtarsal motion are full and pain free. Foot position is mildly PV. Gait is reciprocal. There is focal tenderness over the hallux MTPJ. There is pain with passive ROM of the left hallux MTJP, worse with plantar flexion. Left foot radiographs show no fracture, dislocation or significant degenerative changes. The bony relationships at the Lisfranc joint are anatomic. Her dorsal 1st MT head appears to be well preserved. Impression is persistent left hallux MTPJ pain following previous cheilectomy which was complicated by wound dehiscence. Her symptoms do not appear to be related to RSD. Additional conservative treatments were recommended. She may need revision arthroscopy and cheilectomy versus fusion as a salvage procedure. She was provided an injection.

The patient returned on November 25, 2009. She reported significant but temporary relief with the injection. Her pain appears to be intraarticular. As her most recent plain films do not look like a very adequate cheilectomy was performed, she is a candidate for revision arthroscopy and cheilectomy. She could always undergo a fusion later as a salvage procedure.

Request for revision arthroscopy and cheilectomy was considered in review on December 4, 2009 with recommendation for non-certification. According to the DDE of September 14, 2009 the patient complains of pain and tenderness over the left big toe and first metatarsal which is exacerbated by weight bearing. There is apparently a bone scan that shows findings consistent with RSD and an occult fracture (not available to the DDE). Radiographs taken on May 8, 2008 are stated to show sclerosis consistent with an occult fracture (not submitted to the DDE). The patient is reported to have had a surgery, however, the op report was not submitted to the Designated Doctor. Per the DD, left big toe ROM was restricted and there was no evidence of a Morton's neuroma. The patient was placed at MMI. A peer discussion was realized. The request is non-certified with rationale that there is no imaging study demonstrating any continuing pathology in the left foot that requires a revision procedure or fusion procedure. There is no obvious fracture or evidence of osteoarthritis necessitating a fusion nor is there significant demonstration of reduced function that would require the requested procedure.

Request for reconsideration, revision arthroscopy and cheilectomy was considered in review on December 22, 2009 with recommendation for non-certification. On November 11, 2009 the patient was noted to have a non-antalgic gait. Upon standing, the patient's foot position is mildly varus and focal tenderness is present on the left hallux metatarsal phalangeal joint. Radiographs are reported as normal. The patient was recommended to continue with conservative treatments. She also underwent with good response. It was claimed that the most recent films demonstrate inadequate cheilectomy. A peer discussion was attempted but not realized. As the radiographs were reported as normal, there is no indication of need for a revision surgery based on radiographic evidence of a supposed inadequate cheilectomy.

Request was made for an IRO.

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

Criteria for ankle fusion include, 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.

References indicate imaging signs of hallux rigidus include, non-uniform joint space narrowing, widening/flattening 1st MT head plus base proximal phalanx, subchondral sclerosis or cysts, horseshoe shaped osteophytes, lateral greater than medial osteophytes and sesamoid hypertrophy. The surgical treatment for hallux rigidus is determined by the extent of the arthritis and deformity. For the more minor type of hallux rigidus, shaving the bump of the bone on top of the metatarsal is sufficient (a cheilectomy). As the stiffening of the big toe joint increases a cheilectomy is not sufficient and an additional bone cut may be needed on the big toe itself, (an osteotomy of the phalanx).

The patient is reporting, swelling and a focus of pain at the medial plantar surface of her left heel. There is tenderness over the entire plantar fascia and toe range of motion is significantly limited. Per a specialty examination, previous cheilectomy which was complicated by wound dehiscence, her symptoms do not appear to be related to RSD, additional conservative treatments were

recommended and she may need revision arthroscopy and cheilectomy versus fusion as a salvage procedure. In September 2009 X-rays shows soft tissue edema, otherwise a normal study. The patient demonstrated swelling and a focus of pain at the medial plantar surface of her heel as well as discomfort at the hallux with limited motion. Ankle range of motion is normal but toe range of motion was significantly limited. Radiographs taken on May 8, 2008 showed sclerosis consistent with an occult fracture.

It has been determined that the patient does not have RSD. The patient has been walking on her heel as it is too painful to walk normally. She reports a pain level of 7-8/10. There is swelling and a focus of pain at the medial plantar surface of her heel. She has discomfort at the hallux as well with limited motion. According to the provider, the most recent films demonstrate inadequate cheilectomy. Loss of motion in the joint has been documented. Sclerosis of the joint has been established. Insufficient cheilectomy has been reported. A fusion procedure or a repeat cheilectomy would be supported at this time.

Therefore, my recommendation is to disagree with the previous non-certification for revision arthroscopy and cheilectomy versus hallux MTP fusion.

The IRO's decision is consistent with the following guidelines:

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

The Official Disability Guidelines - Ankle and Foot Chapter (12-18-2009): Ankle Fusion:

Recommended as indicated below. Also see Surgery for calcaneal fractures.

ODG 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.

Wheless Online Textbook of Orthopedics: [http://www.whelessonline.com/ortho/hallux_rigidus_and_cheilectomy]

Exam:

- skin irritation due to pressure from footwear over dorsal exostosis
- on exam, decreased ROM, esp dorsiflexion, is common;
- limitation of motion and pain at the MTP joint of the great toe secondary to prominent marginal osteophytes; absence of passive MTP dorsiflexion, often normal or adequate plantarflexion
 - affected feet are often long, narrow, & pronated with unstable arches, frequently with a hyper-mobile or elevated (and long) first MT;
 - need to rule out "pseudo-hallux rigidus"
 - nodular swelling of the proximal FHL which limits hallux dorsiflexion;
 - FHL becomes constricted within the fibro-osseous tunnel;
 - hallux motion is restored when ankle is plantar flexed;

- X-ray:

- non-uniform joint space narrowing
- widening/flattening 1st MT head + base proximal phalanx
- subchondral sclerosis or cysts
- horseshoe shaped osteophytes
- lateral > medial osteophytes
- sesamoid hypertrophy
- Non Operative Treatment:
 - includes molded stiff inserts w/ rigid bar or rocker bottom shoe;
- Surgical Treatment:
 - surgical indications:
 - cheilectomy for treatment of hallux rigidus will relieve dorsal impingement that is usually the source of pain in patients w/ this condition;
 - cheilectomy is recommended for mild to moderate deformity;
 - arthrodesis: is treatment of choice following failed cheilectomy or where advanced degenerative changes are present;

Outcomes: In the study by T. Muller MD 1999, there were 14 excellent, 7 good, and one fair result, and radiographic progression was seen in 7/13 patients.

Operative technique: Removal of bone spurs alone is usually not sufficient for pain relief;

- cheilectomy, which includes not only excision of dorsal spur & dorsal 1/3 the metatarsal head, gives long-term pain relief in most patients;
- it important to remove the dorsal 20-30% of metatarsal head, along with any spurs that may have formed along lateral side of the joint;
- when performing a cheilectomy, most common error is to remove dorsal exostosis in line with dorsal surface of the metatarsal
 - rather than remove dorsal 20% to 30% of bone;
- it is key to note that a large portion of the motion achieved intra-operative will be lost post-operatively, hence supra-normal amounts of dorsiflexion of the great toe needs to be obtained intra-operatively;
- some surgeons will shoot for 60-80 deg of dorsiflexion;
- range of motion of the hallux should be initiated soon after surgery;

The online Institute for Foot and Ankle Reconstruction at Mercy - The Stiff Big Toe Joint (Hallux Rigidus): The surgical treatment for hallux rigidus is determined by the extent of the arthritis and deformity. For the more minor type of hallux rigidus, shaving the bump of the bone on top of the metatarsal is sufficient (a cheilectomy). As the stiffening of the big toe joint increases a cheilectomy is not sufficient and an additional bone cut may needed on the big toe itself, (an osteotomy of the phalanx). [http://www.mdmercy.com/footandankle/conditions/bigtoe/hallux_rigidus.html]