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Notice of Independent Review Decision

**DATE OF REVIEW:** APRIL 4, 2011

**IRO CASE #:**

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

Remodel Cuboid due to Malunion and Ulcer of Left Foot 28122

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

This physician is a Board Certified Orthopedic Surgeon.

**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 or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

On xx/xx/xx claimant attended office visit appointment with D.P.M. For a wound to his left lateral foot. Integumentary exam shows the left foot has a discontinuity of skin with granular/fibrous base consistent with an ulcer; erythema extends around the ulcer, very local. Vascular exam states left foot pedal pulses are palpable. Dorsalis pedis 1 / 4, posterior tibial 1 / 4, capillary refill time is less than three seconds to digits 1-5. There is no evidence of pedal edema. There is no evidence of venous insufficiency, both deep and superficial. Musculoskeletal exam state overall rectus foot shape, except the fifth toe is varus and/or contracted No other gross bony abnormalities noted. Adequate range of motion at the ankle joint, sub-talar joint, midtarsal joint or first metatarsal phalangeal joint, of both right and left foot. No pain on palpation at any location, except fifth toe. O pain on ROM at any other location. Assessment states Ulcer Improving continue wound care with home health. Reviewed note from PCP. Advised to continue antibiotic. Will follow at WCC Monday.

On February 6, 2009 was seen by, D.P.M. for a follow up visit for an ulcer on the lateral side of his left foot. The assessment states 1. Ulcer Left lateral foot. Unchanged, will continue daily wound care with home health. Reviewed x-ray and radiologist report of x-ray and MRI. Also, previous x-ray from previous facility is available. Discussed with claimant that he appears to have osteomyelitis in the remaining portion of fourth and fifth MT. D.P.M. states that he believes that the claimant's ulcer will more likely heal with resection of these two portions of bones. Claimant understands and agrees to schedule revision surgery. 2. Diabetic-Neuropathy with drop foot. Claimant wears and AFO on right foot at this time. 3. Acute osteomyelitis left foot. Will return for surgical consultation visit.

On February 13, 2009 claimant was see for consultation for surgery on the left foot with D.P.M. Assessment states 1. Diabetic Neuropathy, 2. Acute osteomyelitis, 3. Surgical Consult resection of remaining 4<sup>th</sup> and fifth MT, left.

On February 16, 2009 the claimant underwent surgery for osteomyelitis of the left foot. The surgical report by Dr. states that the post operative diagnosis remained osteomyelitis of the left foot. The procedure performed was amputation of remnants of the fourth and fifth metatarsals left foot.

On February 19, 2009 the claimant was in for POW 1 with Dr. for left resection 4<sup>th</sup> and 5<sup>th</sup> met. Integument exam states minimal edema, minimal discoloration, no sign of infection, no drainage, or odor, sutures are in place with no dehiscence. Ulcer has granular base. Vascular exam states pedal pulses are palpable. Dorsalis pedis 2 / 4. Posterior tibial 2 / 4, capillary refill time is less than three seconds to digits 1-5. There is no evidence of pedal edema; there is no evidence of DVT. Musculoskeletal exam states overall rectus foot shape. Adequate ROM at the ankle joint, midtarsal joint or first metatarsal phalangeal joint, of both right and left foot. Slight pain noted at surgical site with range of motion and/or palpation. Assessment states Post op visit will write orders for wound VAC. Continue daily wound dressing until VAC. Continue antibiotics. Plan Instructions ambulate to tolerance with surgical shoe/fracture boot.

On February 26, 2009 the claimant was in for POW 2 with Dr. for resection of the 4<sup>th</sup> and 5<sup>th</sup> met, possible suture removal. Integument examination states minimal edema, minimal discoloration, no sign of infection. No drainage or odor. Sutures are in place with no dehiscence. Ulcer has granular base. Procedure states sterile dressing applied. Assessment states 1. post op visit will remove sutures next visit. Continue with antibiotics, daily home health, and wound VAC is pending; 2. Diabetic-Neuropathy.

On March 5, 2009 claimant was in for POW 3 with Dr. for resection of the 4<sup>th</sup> and 5<sup>th</sup> met, suture removal. All assessments unchanged. Assessment states 1. Post op visit continue with antibiotics VAC is pending and claimant is doing his own dressing changes. He still might get to go to WCC if covered by workers comp. 2. Diabetic Neuropathy.

On March 19, 2009 claimant was in for POW 5 with Dr.. Claimant states he has a wound vac but no nurse to put it on. Claimant states he changes his dressing daily. Integument exam indicates minimal drainage and no odor. Retention suture are in place with no dehiscence. Ulcer has granular/fibrous base, approx. 4cm x 6cm. Procedure Ulcer debridement states the ulcer base was debrided down to bleeding removing fibrous and necrotic tissue. The hyperkeratotic rim was debrided. Ulcer is approx 4cm x 6cm. Assessment states will follow up at WCC he has been approved, he has a wound vac delivered, but does not have it applied yet. Remaining suture removed. 2. Acute osteomyelitis left foot may be resolved from excision of bone.

On May 19, 2009 claimant was seen at an office visit by DPM he was referred by Dr. for Charcot foot, left foot. Integument examination states there is a discontinuity of skin with a fibrous and granular base and a hyperkeratotic rim at the lateral midfoot which measures 48 x 23 mm it does not probe to bone. No erythema extends around the ulcer, no pus is evident. It is malodorous. Vascular examination states there is plus 4 pitting edema of the entire left foot and ankle. It is slightly warm to the touch, the pedal pulses are not palpable due to the edema. Neuromuscular examination states there is severe sensory loss, pt. asensate from mid calf distally. Musculoskeletal examination states there is amputation of the fourth and fifth ray, the hind foot and ankle on the left appear normal grossly normal, there is severe edema of the forefoot, but otherwise normal gross forefoot alignment despite the radiographic signs of dislocation of Lisfranc's joint to the remaining medial three metatarsals. The right is unaffected. Procedure foot xray/professional component. Assessment 1. Diabetic ulcer continue wound vac, ABx, I recommend getting the ulcer healed before doing surgery, also recommend pt be completely off weight bearing left side. 2. Charcot foot pt is responding well to ABx and cast gait/offloading. Complete not weight bearing recommend as a long term plan to reduce edema, tune pt up and reconstruct forefoot with internal fixation and application of external frame.

On May 22, 2009 claimant was seen at an office visit by Dr. integument exam states ulcer to lateral left foot not examined due to wound vac being applied today. Mild erythema to the dorsal foot consistent with active charcot. Vascular exam states left foot pedal pulses are palpable but decreased. Dorsalis pedis 1 /

4. Posterior tibial 1 / 4 capillary refill time is less than three seconds to digits 1-5. There is no evidence of pedal edema. There is no evidence of venous insufficiency, both deep and superficial. Musculoskeletal exam states overall foot shape shows collapsed medial arch and edema consistent with a Charcot deformity of the midfoot. Assessment 1. Diabetic ulcer 2 Diabetic neuropathy with Charcot joint discussed the high risk of loss of limb and ulceration with the claimant. Discussed diabetic foot care and the need for surgical intervention after the ulcer has healed more.

On June 29, 2009 claimant was seen for a follow up office visit with Dr. DPM. Integument exam states the area at the lateral midfoot has a discontinuity of skin with a fibrous and granular base and a hyperkeratotic rim, it measures 48 x 28 mm it does not probe to bone, no erythema extends around the ulcer, no pus is evident, it is not malodorous. Vascular exam states there is 4 pitting edema of the entire left foot and ankle and it is slightly warm to the touch, the pedal pulses are not palpable due to edema. The musculoskeletal exam states there is amputation of the fourth and fifth ray, the hind foot and ankle on the left appear normal grossly normal, there is severe edema of the forefoot, but otherwise normal gross forefoot alignment despite the radiographic signs of dislocation of Lisfranc's joint to the remaining medial three metatarsals. The right is unaffected. Assessment Dr. discussed with the claimant that at the current time he did not think the claimant would be a good candidate for surgery due to the fact the wound was not completely healed and concern about the possibility of a low grade infection as well as the claimant's resolve to have a Charcot reconstruction with external fixator done requiring him to be non weight bearing for 3 months referred back to Dr. until the wound is healed

On July 21, 2009 claimant is seen for a follow up office visit with Dr. DPM. Integument exam states there is an area at the lateral midfoot, which has a discontinuity of skin with a fibrous and granular base and a hyperkeratotic rim, it measures 14 x 17 mm it does not probe to bone. No erythema extends around the ulcer, no pus is evident. It is not malodorous ankles and lower legs except the ulcer on the plantar right foot is decreased in size for the first time. Vascular exam states there is 4 pitting edema of the entire left foot and ankle and it is slightly warm to the touch, the pedal pulses are not palpable due to edema. Neurologic exam states severe sensory loss, pt. asensate from the mid calf distally. The musculoskeletal exam states there is amputation of the fourth and fifth ray, the hind foot and ankle on the left appear normal grossly normal, there is severe edema of the forefoot, but otherwise normal gross forefoot alignment despite the radiographic signs of dislocation of Lisfranc's joint to the remaining medial three metatarsals. The right is unaffected. The right foot is moderately edematous, especially at the midtarsal joint. There appears to be gross subluxation at Lisfranc's joint. The midfoot is twice its normal thickness with no motion at the Lisfranc's joint, he is definitely severely subluxed there as evidenced on radiographs last visit. Motion at the subtalar joint on the affected side is extremely limited. Assessment: 1. Diabetic ulcer; 2. Charcot foot follow up. Discussed with claimant that he has progressive anemia therefore will discuss surgery with Dr. to optimize the claimant's healing capacity.

On August 11, 2009 claimant is seen for a consultation for medial and lateral column fusion with application of external ring frame with Dr. DPM. Assessment states 1. Lisfranc's fx dislocation 4 months; 2. Surgical consult.

On August 16, 2009 phone conversation between claimant and Dr. DPM. Stating that claimant was having shooting pain in the foot, related neuropathy type pain, very intense, no sign of infection, has not had pain advised pt to keep scheduled appt. and to go to emergency room if condition worsens or if sign of infection

On August 20, 2009 claimant was seen at the wound care center for follow up of an ulcer on his left foot. The midfoot has dislocated and fractured since his ray resections. Integument exam states the left foot has a discontinuity of skin with a granular base consistent with an ulcer. No erythema extends around the ulcer much improved with granular base. 80% reduced from original no sign of infection. Small dorsal ulcer on dorsum of great left toe no sign of infection. Vascular exam left foot pedal pulses are palpable but decreased in both right and left feet. Neurological exam states decreased sensation to all dermatomes, with a 10 gram monofilament wire, both right and left foot. Musculoskeletal exam states overall foot shape shows collapsed medial arch, edema has improved. Dislocation noted at midfoot with dorsal bump. Right foot is rectus. Procedure the ulcer base was debrided down to bleeding removing fibrous and necrotic tissue. The hyperkeratotic rim was debrided. Assessment: 1. Lisfranc's fracture and dislocation 2. Diabetic neuropathy 3. Ulcer.

On October 5, 2009 claimant attended a follow up appointment with Dr. DPM. Musculoskeletal exam states edema to the left foot, unable to do range of motion due to the exquisite pain. The Lisfranc's joint is definitely stiff and crepitant, gross deformities reveal a subluxation and what appears to be a lateral subluxation of the cuneiform as well as lateral subluxation of the lesser metatarsals. Assessment fracture/dislocation Lisfranc's left foot the severity of the deformity will likely result in re ulceration of the plantar foot if her returned to any semblance of normal activity, claimant's only option would be wearing a "CROW" walker for the rest of his life which is a poor alternative when surgical reconstruction is a viable option, ABI tests reveal adequate peripheral vascular status, and he has cardiac clearance on prior visit for spinal anesthetic.

On November 9, 2009 claimant is seen for consultation for charcot foot reconstruction with external ring frame left foot and ankle.

On November 25, 2009 surgery was performed by Dr. DPM pre op diagnosis was 1) Lisfranc dislocation with degenerative joint disease, left foot; 2) gastrocnemius, left. Post op diagnosis remained the same. Procedure performed was 1: tenodoachilles lengthening, left; 2. Arthrodesis of the medial and lateral columns; 3. Application of external fixator; 4. Intraoperative fluoroscopy.

On December 7, 2009 claimant was seen for POW 2 by Dr. DPM. Assessment states 1<sup>st</sup> post op dressing change states that claimant has a pin tract infection and will need home health to come change the dressing daily. Claimant placed on Bactrim every 12 hrs, cultures were taken of the pin tract infection.

On December 11, 2009 notation made by Dr. DPM of peer to peer regarding the need for home health care. Home health care approved by WC physician.

On December 14, 2009 claimant is seen for 3 week post op visit claimant c/o drainage from surgical site and shift in hardware due to broken piece. Procedure left x-rays 2 views AP/lateral tib-fib the dorsal lateral half pin was noted through the tibia and fibula. The hardware is intact without any fractures or dislocations noted, good alignment noted. Assessment states all clamps, rods and half pins were loosened. All clamps were tightened and the half pin on the dorsal lateral aspect of the tibia was backed out until there were visible threads. Education and reinforcement regarding restrictions and clamp care.

On December 15, 2009 Dr., DPM completed peer to peer for continuation of home health care, WC physician agreed.

On December 21, 2009 claimant in for POW 4 with Dr. assessment : status post charcot reconstruction with ex fix application. Will continue claimant on antibiotics, home health care, NWB.

On January 4, 2010 claimant in for follow up office visit with Dr. Integument exam states mild serosanguinous drainage and mild erythema at proximal pin sites. Incision to lateral-inferior foot shows eschar tissue. Incision to dorso-lateral foot shows mild dehiscence with fibrotic base. Vascular exam states there is moderated edema consistent with surgery and no ecchymosis around the ExFix. Assessment states continue NWB, dressings changed daily, begin back on bactrim.

On January 7, 2010 claimant is seen for visit with DPM, musculoskeletal exam states there is obvious displacement when the claimant picks up his leg at the tibia, there is instability noted on elevation of the leg at the mid shaft tibia. Assessment states hardware complication above knee splint was placed on the claimant with knee bent at forty five degree angle, claimant was admitted to the hospital

On January 20, 2010 note states that Dr., DPM discussed with work comp physician that claimant is homebound and needs Lovenox injections daily due to high risk of DVT.

On January 20, 2010 claimant attended office visit with Dr. DPM for POW 8-9 L arthrodesis. Procedure was cast modification. Assessment leave cast on two more weeks.

On February 9, 2010 claimant attended office visit with Dr. DPM for POW 14/L arthrodesis. Musculoskeletal exam state alignment of foot and ankle satisfactory,

no change in position or change or disruption of the internal or external fixation. Good ROM of the forefoot/toes on the surgical side are excellent. February 9, 2010 appt. with Dr. DPM procedure remove b-k cast

March 8 2010 follow up appt with Dr. DPM musculoskeletal exam states there appears good gross osseous alignment of the forefoot and the MTP joints. Overall position satisfactory at the surgical site on the left foot. Range of motion of the ankle 20-30 degrees without pain. Assessment states malunion of metatarsal fracture discussed with the claimant that his foot is solid and healed, will get impression for custom orthotics and shoe gear.

April 10, 2010 follow up appt with Dr., DPM, POW20 amputation of 4<sup>th</sup> and 5<sup>th</sup> digit left foot. Neurological exam states claimant is basically asensate from the ankle distally, musculoskeletal exam states forefoot to hindsfoot alignment good. Severe weakness of the posterior group.

June 7, 2010 claimant in for s/p 18 weeks Charcot Reconstruction with Dr. DPM. Gait analysis exam states claimant has extremely poor push off with abnormal angle and base of gait. The gait is rotated externally with poor push off. The foot is held somewhat supinated.

December 7, 2010 claimant in to see Dr., DPM for follow up on workers comp injury to the left foot, Charcot, 2 years back. Musculoskeletal exam states motion at the subtalar joint on the affected side is extremely limited. Evaluation of ankle ROM reveal +5 degrees of dorsiflexion at the ankle with the knee extended. There is +10 degrees of dorsiflexion with the knee flexed. MTP and IP joints are essentially normal with no gross osseous abnormality noted.

January 28, 2011 claimant in to see Dr. DPM for drainage/sore left foot. Integument exam states the left foot has a discontinuity of skin with granular/fibrous base consistent with an ulcer. Serous drainage. Erythema extends around the ulcer. Vascular exam left and right foot pedal pulses are palpable but decreased Dorsalis pedis 1/4, posterior tibial 1/4 capillary refill time is less than 3 seconds to digits 1-5. Musculoskeletal exam states overall foot shape shows collapsed medial arch, edema has improved. Dislocation noted at midfoot with dorsal bump. Assessment states 1. Diabetic-neuropathy with Charcot joint. 2. Cellulitis with ulcer plantar started antibiotics NWB with crutches

January 31, 2011 claimant in to see Dr., DPM Integument exam sites left plantar midfoot ulceration. Undermining with peri-wound maceration. + probing, no frank drainage today, mild erythema. Assessment 1. Diabetic ulcer debridement of devitalized tissue. 2. Cellulitis foot continue cipro and doxy as previously prescribed

February 5, 2011 Dr. telephone conversation with, nurse at home health, relates that she is unable to get to claimant's home because of mud/weather. Advised pt

to wash wound daily with soap and water, apply silvadene and dressing daily and home health will follow up ASAP.

February 7, 2011 follow up appt with Dr. DPM for cellulitis left foot secondary to ulceration on the plantar lateral aspect of his left foot. Integument exam states the ulcer decreased erythema it is now 15 mm in diameter and 10 mm deep on the plantar left foot beneath the cuboid bone. There is no probing to the bone. Vascular exam state PT pulse is palpable, DP is non palpable, capillary refill time is less than 5 seconds. Musculoskeletal exam states prominent cuboid at plantar lateral midfoot LEFT, rays 4 and 5 have previously been amputated.

February 14, 2011 claimant in for follow up appt with Dr. DPM for ulcer/cellulitis bottom of left foot. Integument exam states ulcer shows decreased erythema it is now 1.5 x 0.8 cm with a granulation tissue base, there is approximately 1 cm of undermining proximally, laterally, and medially. There is no evidence of purulent or other drainage. It is decreased in size with improvement of erythema, drainage, and edema since last visit. Mild HPK tissue surrounding margin. Sloughing skin from remaining blister removed. Pink, healthy, granular skin noted below. Vascular exam states pulses palpable, CRT <5 sec. skin warm. Musculoskeletal prominence to plantar lateral foot under 5<sup>th</sup> base/cuboid. Procedure ulcer debridement full thickness.

On February 21, 2011 claimant in for follow up appt with Dr. DPM for ulceration on left foot. Integument exam states the ulcer shows decreased erythema it is now 19 x 32 mm on the plantar left foot at the fifth metatarsal base area. It is decreased in size with significant resolution of erythema, drainage and edema since last visit. Granuloma present to ulceration. Left plantar midfoot ulceration. Undermining with peri-wound maceration + probing no frank drainage today. Mild erythema. Neurological exam states the claimant is basically asensate from the ankle distally. Procedure ulcer debridement kin full thickness 11041 left.

On February 28, 2011, M.D. performed a UR on the claimant. Rationale: ODG Antifungal does not address this request not are there international guidelines available for this request. The request is not certified. Currently the claimant has a healing but open ulcer in the left foot. There is no direct physical exam of the cuboid or indication of how remodeling the cuboid would reasonably improve the claimant's functional ability. The clinical documentation is limited to evaluation of the ulcer only and there is no in depth exams regarding ankle instability or gait analysis that would reasonably support the request for the procedure.

On February 28, 2011 claimant in for follow up appt with Dr. Subjective state pt who is s/p left midfoot fracture with non-union after a crush injury in xx/xx. He healed uneventfully, however he has developed an ulceration along the plantar lateral column. We have tried off loading, debridement, orthotics, and currently the claimant is in a fracture boot with offload insole. The ulcer does not appear infected but it is not healing remaining about 1.5 x 3.0 cm in diameter. Integument exam state ulcer plantar left foot sub 5<sup>th</sup> metatarsal/cuboid is clinically improved, now measures 15 x 29 x 0.2 mm with 70/30 granulation/fibrous tissue

base, some hypergranulation present. There is no erythema, edema or signs of purulent drainage. There is no undermining sinus tract formation, or probing to bone. Vascular pedal pulses are 2+, capillary refill time is less than 5 seconds. Neurological loss of protective sensation to 5.07 mm monofilament to the level of the ankle. Patellar and Achilles reflexes are absent. Musculoskeletal exam states there is a palpable boney hypertrophy with palpation directly at the ulcer site on the left foot. The hindfoot and forefoot are rectus. No other changes noted. Gait analysis exam states there is severe antalgia of gait with prolonged midstance and definite dropfoot with overload of the lateral column. Procedure x-ray limited left there is definite boney hypertrophy at the ulcer as indicated by the marker over the ulcer. The midfoot looks fused. Assessment ulcer due to malunion of fracture follow up discussed with claimant that the only way to get the ulcer healed would be to remove the hypertrophic bone plantarly causing the ulcer.

On March 4, 2011, DPM performed a UR on the claimant. Rationale: The request is not certified. The only clinical documentation submitted for review is a letter dated 2/28/11 recommending surgery secondary to possible development of osteomyelitis. There are no clinical visit notes that contain subjective and objective clinical findings to support the procedure. There is no documentation of prior conservative care. In addition, there is no prior imaging or bone scan studies submitted for review.

March 7, 2011 claimant in for follow up with Dr., DPM for ulceration left foot. Integument exam states the plantar ulcer on the left foot is unchanged in size from the previous week. It has a 100% granular base it measures 1.5 x 3.0 cm. There is no drainage or odor noted but some increase in the surrounding erythema. Neurological exam states severe sensory loss, pt. asensate from the mid calf distally. Procedure ulcer debridement partial thickness. Assessment since the ulcer is not responding to current treatment will continue wound care change to duoderm, continue fracture boot, off loading, and daily redressing. I recommended resection of bone on the plantar lateral foot.

#### **PATIENT CLINICAL HISTORY:**

Insulin Dependent Diabetes, previous Podiatric surgeries: toe amputated 2001 and July 2008.

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

Reason for upholding the denial for request to perform a 'remodeling of the cuboid': I reviewed the records and have determined that the procedure requested by, DPM should be denied.

Briefly, the claimant apparently sustained a crush injury on the job in xx/xx. This then went on to a charcot foot. The claimant was followed by a DPM, DPM and a

third DPM from January 2009 through March 28, 2011. The claimant had an ulceration of the lateral foot upon initial presentation. This was managed somewhat conservatively with wound care, and attempts at offloading via inserts for a couple of years. He underwent resection of the 4<sup>th</sup> and 5<sup>th</sup> metatarsals 2/16/2009. He underwent a medial and lateral column fusion, with internal fixation, Achilles lengthening and external fixation application 11/25/2009. This fusion procedure, performed for a 'dislocated Lis-franc joint in the charcot foot', apparently had some complications. In the records there was displacement, medialdorsal dislocation, instability, pin tract infections and hardware complications. Subsequently, the claimant developed a plantar ulceration, laterally based presumably. This is the site of the 'bony remodeling' that is requested to be performed.

I would deny this surgery as it is probably a poorly indicated procedure where an actual revision of the fusion should be performed. The diagnosis for which this is requested is a 'malunion of metatarsal fracture'. However, I would posit that this is an iatrogenic malunion of a mid-foot fusion performed in November of 2009. This is my reasoning based on records review without actually visualizing any films.

### **Per ODG**

#### **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.

([Washington, 2002](#)) ([Kennedy, 2003](#)) ([Rockett, 2001](#)) ([Raikin, 2003](#))

For average hospital LOS if criteria are met, see [Hospital length of stay](#) (LOS).

**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)