C-IRO Inc.

An Independent Review Organization
1108 Lavaca, Suite 110-485
Austin, TX 78701
Phone: (512) 772-4390
Fax: (512) 519-7098
Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/02/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient Left Ankle Explore Fusion, Remove Hardware, Arthrodesis Fusion, Joint w.Plate-Screw Fixation 27870 20680 20902

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D. Board Certified Orthopedic Surgeon

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[ ] Upheld (Agree)
[X] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines, Treatment in Worker's Comp 16th edition, 2011 Updates. Ankle and Foot.
MRI left ankle 12/01/08
Dr. office notes 05/21/09, 06/04/09, 08/03/09, 8/20/09, 9/3/09, 10/15/09, 11/5/09, 02/04/10, 04/08/10, 05/27/10, 08/26/10, 09/23/10, 03/09/11
X-ray report left ankle 05/26/09
Operative report 08/05/09
X-ray report left foot 05/19/10
Physical therapy discharge summary 06/30/10
FCE report 07/19/10
Dr. evaluation 07/22/10
Dr. procedure report 08/03/10
CT report left ankle 09/23/10
Peer review reports 03/01/11, 03/25/11

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a female with a left ankle fracture on xx/xx/xxxx when she fell down stairs. She underwent open reduction internal fixation in 1997-98 and removal of screws in 1999. She began treating in 2009 for left ankle pain with a diagnosis of degenerative joint disease. On 08/05/09 Dr. performed a left ankle tibiotalar fusion.

Office visits in 2010 noted the claimant with midfoot and forefoot pain. The claimant had four visits of physical therapy in February and March 2010 with noted independence with a home exercise program. X-ray on 05/19/10 showed apparent solid bony fusion. The diagnosis at the 05/27/10 visit was degenerative joint disease of the transverse tarsal joint secondary to tibiotalar fusion.

On 08/03/10 Dr. performed a left talonavicular injection and a left talocuboid injection. There

was no change in symptoms following the injections. CT scan of the left ankle on 09/23/10 showed the previous ankle arthrodesis with incomplete bony ankylosis. The medial most fixation screw extended slightly into the tarsal canal. There was patchy osteopenia, thought to be disuse osteopenia and atrophy of the muscles in the mid and hindfoot thought to be related to disuse. There were scattered areas of mild degenerative narrowing involving the talocalcaneal joint, calcaneocuboid joint, the joints between the cuneiforms, and the first metatarsotarsal joint.

On 09/23/10 Dr. recommended exploration and removal of screws. If the ankle was not fused he planned bone graft and plate fixation. The surgery was denied on peer review of 03/01/11. The records contain an office visit of 03/09/11 with Dr. Exam findings included pain to palpation of the mid foot at the transverse tarsal, tarsometatarsal, calcaneocuboid joints and palpable crepitus and grinding to passive motion to dorsi and plantar flexion. The diagnosis was incomplete left tibiotalar arthrodesis; mild forefoot hindfoot degenerative changes. Dr. again recommended surgery, which was denied on peer review of 03/25/11.

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

The Official Disability Guidelines does not specifically discuss the indications for treatment of a painful pseudarthrosis. In general the treatment would include a period of conservative care and a careful assessment of an individual's functional difficulties attributable to pain related to the pseudarthrosis. For those individuals where there is documented evidence of pseudarthrosis on imaging and other forms of conservative care have failed, surgical exploration of the pseudarthrosis with repair of the pseudarthrosis would be considered reasonable and appropriate. In this particular case, there is sufficient information to support that Dr. recommendation would be medically necessary. He has a CT scan from 09/23/10 that documents a pseudarthrosis. He has documented findings of crepitus on examination with attempts at dorsiflexion and plantar flexion that would suggest incomplete fusion. Furthermore, the individual has persistent pain in that location. In addition, there is pain over the screw sites. The indication for surgery in this case would not appear to be painful hardware, but would rather be a potentially painful pseudarthrosis. For these reasons, the request for Outpatient Left Ankle Explore Fusion, Remove Hardware, Arthrodesis Fusion, Joint w.Plate-Screw Fixation 27870 20680 20902 is found by the reviewer to be medically necessary.

Official Disability Guidelines, Treatment in Worker's Comp 16th edition, 2011 Updates. Ankle and Foot.

Hardware implant removal (fracture fixation)

Not recommend the routine removal of hardware implanted for fracture fixation, except in the case of broken hardware or persistent pain, after ruling out other causes of pain such as infection and nonunion. Not recommended solely to protect against allergy, carcinogenesis, or metal detection. Although hardware removal is commonly done, it should not be considered a routine procedure. The decision to remove hardware has significant economic implications, including the costs of the procedure as well as possible work time lost for postoperative recovery, and implant removal may be challenging and lead to complications, such as neurovascular injury, refracture, or recurrence of deformity. Current literature does not support the routine removal of implants to protect against allergy, carcinogenesis, or metal detection. (Busam, 2006) Despite advances in metallurgy, fatigue failure of hardware is common when a fracture fails to heal. Revision procedures can be difficult, usually requiring removal of intact or broken hardware. (Hak, 2008) Following fracture healing, improvement in pain relief and function can be expected after removal of hardware in patients with persistent pain in the region of implanted hardware, after ruling out other causes of pain such as infection and nonunion. (Minkowitz, 2007) The routine removal of orthopaedic fixation devices after fracture healing remains an issue of debate, but implant removal in symptomatic patients is rated to be moderately effective. Many surgeons refuse a routine implant removal policy, and do not believe in clinically significant adverse effects of retained metal implants. Given the frequency of the procedure in orthopaedic departments worldwide, there is an

urgent need for a large randomized trial to determine the efficacy and effectiveness of implant removal with regard to patient-centred outcomes.

Fusion:

Recommended as indicated below. In painful hindfoot osteoarthritis the arthroscopic technique provides reliable fusion and high patient satisfaction with the advantages of a minimally invasive procedure. (Glanzmann, 2007) 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.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)