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Notice of Independent Review Decision

DATE: October 24, 2012; **AMENDED October 24, 2012**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

LT Midfoot Fusion Inpatient – 24 Hours

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

This physician is Board Certified by the American Board of Orthopaedic Surgery with over 42 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

08/12/11: Operative Report by MD with Medical Center
08/15/11: Operative Report by MD
02/09/12: General Orthopaedic Clinic Note by MD with Center
05/10/12: General Orthopaedic Clinic Note by MD
09/06/12: General Orthopaedic Clinic Note by MD
09/11/12: Orthopaedic Clinic Note by MD
09/20/12: Preauthorization Request
09/27/12: UR performed by MD
10/05/12: UR performed by MD

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained a work-related crushing injury to his left foot on xx/xx/xx. He is status post left fasciotomy, subsequent I & D and closure, and subsequent ORIF.

08/12/11: Operative Report by MD with Medical Center. POSTOPERATIVE DIAGNOSIS: Left foot compartment syndrome status post a crush injury with a navicular fracture and midfoot subluxation. OPERATION: Left foot fasciotomies.

08/15/11: Operative Report by MD. POSTOPERATIVE DIAGNOSIS: Left navicular fracture. Left midfoot subluxation. Left fifth metatarsal base fracture. OPERATION: ORIF left navicular fracture. Closed reduction and percutaneous pinning of left midfoot. Closed treatment of left fifth metatarsal base fracture. Closure of fasciotomy wounds, left foot. I&D to the level of the muscle left lower extremity fasciotomy wounds.

02/09/12: The claimant was evaluated by MD for a six-month followup postop visit. It was noted that he had been ambulating without assistance as tolerated. He had been back to work. He did complain of pain during his duty at work as well as pain when he would first wake up in the morning, which was significant over the dorsal surface of the midfoot. On physical exam of the left lower extremity, sensation was intact. He had brisk capillary refill. Wounds were healed. There were no signs of erythema, infection, or drainage. He was nontender to palpation over the entirety of the left foot. He was able to ambulate without assistance with no pain with ambulation. His imaging showed what appeared to be a healed fracture with the hardware in position as before. There was a minimal amount of spurring. It was felt that he developed some post-traumatic arthritis from the injury to his midfoot. Overall, his alignment was good at this point. He was released to full duty and was to return for a followup visit in 2-3 months.

05/10/12: The claimant was reevaluated by MD. He was doing well and had been ambulating without assistance. He had minimal pain. He only described pain at the end of the day after he had been on his feet all day and when he sat and felt a moderate pain in the midfoot. On physical exam, his incision was well healed. There were no signs of erythema, infection, or drainage. There was no tenderness to palpation over the midfoot. There was brisk capillary refill. 2+ DP pulse. No pain with palpation or motion in both inversion and eversion, flexion and extension. Imaging showed a healed fracture with some post-traumatic changes throughout the midfoot. Overall, alignment was good. Discussion was made of the possibility of post-traumatic midfoot arthritis secondary to injury possibly requiring fusion in the future. He was to followup on a p.r.n. basis.

09/06/12: The claimant was seen by MD for continued left foot pain. He reported starting a new job at xx approximately three weeks prior to the visit with pain and swelling with ambulation to the left foot and described the pain at the dorsum of the midfoot over the navicular and cuneiform, also base of the 5th metatarsal. He denied any new numbness or tingling and had continued tingling association between the 4th and 5th dorsal web space. The pain had become increasingly worse and he had been now laid off from the job. On physical examination of the left lower extremity, the incision was well healed. There were no signs of erythema, infection, or drainage. He had tenderness to palpation at the base of

the 5th metatarsal, lateral ankle ligaments, and mid foot. He had symmetric arches bilaterally, pain at the tibiotalar junction with heel raise. He had 2+ dorsalis pedis pulse, posterior tibial pulse. There was brisk capillary refill. There was tingling of the deep peroneal nerve. Sensation was intact to superficial peroneal nerve, sural, saphenous, and tibial. Positive EHL and positive FHL. Normal range of motion of the ankle. X-rays showed the hardware in position as before without evidence of loosening or failure. There was some deformity to the navicular consistent with his initial crush injury. There were some osteophytes superiorly over the midfoot. He was to see Dr. for evaluation.

09/11/12: The claimant was evaluated by MD for a second opinion regarding left foot pain. It was noted that he was able to work as a xx for only a few days before the severe pain resulted in his termination. He had both pain and swelling. He described the pain as sharp, throbbing, and constant, which was better with resting and worse with standing. The pain was referred to the midfoot region. On exam, he ambulated with an antalgic gait on the left side. Left foot capillary refill was brisk. Dorsalis pedis pulse was palpable. Range of motion of the left ankle in dorsiflexion was 20 degrees, plantar flexion 45 degrees, subtalar 25% range of motion compared to right. 1st metatarsal phalangeal joint dorsiflexion 60 degrees, plantar flexion 20 degrees. Tender to palpation in the midfoot and medial dorsal surgical incision. Normal arch. Tinel's over medial incision runs to 2nd toe. On neurologic testing, sensation plantar foot intact, vibration sensation intact at toes, light touch intact in toes except the dorsum of the 1st and 2nd toes. CT, left foot xx/xx, Interpretation: Images are reviewed. They show a fracture of the cuneiform proximally, navicular and 5th metatarsal. The posterior facet of the subtalar joint is somewhat abnormal, but I believe this is an artifact of positioning. X-ray, left foot 09/06/12, Interpretation: The navicular is sclerotic. There appears to be degenerative changes at both the talonavicular and naviculocuneiform joints. SUMMARY: The neuropathy on the top of his foot from the surgical incision appears to be minimally symptomatic. I see no intervention at this time. Patient with severe arthropathy of the midfoot secondary to trauma. He appears to have significant changes on both the proximal and distal aspects of the navicular. This is a difficult problem to treat. Options include an orthotic rigid. The other option is for an arthrodesis of the affected joints. This requires the arthrodesis to span the navicular. Nonunion rates are extremely high. Patient would like to explore the option of surgery. We discussed risks with the patient. We will apply to Workers' Compensation for coverage. I don't think his foot will ever be normal, and his ability to work standing on his feet for extended period of time, I believe, will be minimal. I encouraged him to consider a sedentary occupation.

09/27/12: UR performed by MD. BASIS FOR CONCLUSION: Regarding left midfoot fusion, ODG criteria for fusion including conservative care, pain including that which is aggravated by activity and weight-bearing and relieved by xylocaine injection; objective clinical findings of malalignment and decreased range of motion; and positive x-ray confirming presence of: loss of articular cartilage (arthritis) or bone deformity (hypertrophic spurring, sclerosis) or non- or malunion

of a fracture. However, formal imaging reports were not made available for review. In addition, it is unclear why attempts at rigid orthotics were not undertaken. In addition, a diagnostic injection was not performed. Furthermore, there is no documentation of what joints in the midfoot are to be fused. Recommend non-certification. As the surgical request is non-certified, the associated request for inpatient – 24 hours is also non-certified. Attempts at peer to peer discussion were unsuccessful.

10/05/12: UR performed by MD. BASIS FOR CONCLUSION: Based on ODG criteria, the role of the proposed left midfoot fusion in this case cannot appear to be medically warranted. In this case, there is a clear lack of understanding of conservative modalities that have thus far been undertaken in regards to the claimant’s foot. While it is specifically documented that he is with clear understanding of perinavicular osteoarthritic change, there is an extremely high rate of malunion/nonunion associated with this type of procedure as specifically stated by the treating physician’s most recent clinical report. It would be unclear as to why attempts at rigid orthotics the treating physician stated would not be undertaken first in this young individual. In addition, there is still no clinical understanding of any diagnostic injection that was performed for which ODG state would be necessary prior to proceeding with a fusion procedure to the foot or ankle. Given the above clinical information, the specific request for the proposed operative intervention cannot be supported as medically necessary given the clinical records that are available for review. Attempts at peer to peer discussion were unsuccessful.

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

The previous adverse decisions are upheld. I would agree with Drs. and that the surgery should be denied based on the evidence that we have in the records. It is unclear which joints are planning to be fused. A mention was made of a sclerotic navicular, which could indicate avascular necrosis. This would significantly interfere with any fusion involving the navicular. There are no records indicating that ODG criteria of conservative care have been met. If further surgery is contemplated, we would need specific imaging reports, such as x-ray reports of specific joints, and mention of the specific joints to be fused. It would also help to have diagnostic blocks with the results involving specific joints. The request for LT Midfoot Fusion Inpatient – 24 Hours is not medically necessary and is non-certified. As the fusion surgery is not medically necessary, the inpatient stay would not be needed either.

ODG:

Fusion (arthrodesis)	<p>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) In stage III and IV adult acquired flatfoot due to posterior tibial tendon dysfunction, correcting and stabilizing arthrodeses are advised. (Kelly, 2001) Also see Surgery for calcaneal fractures; Surgery for posterior tibial tendon ruptures.</p> <p>ODG Indications for Surgery™ -- Ankle Fusion: Criteria for fusion (ankle, tarsal, metatarsal) to treat non- or malunion of a fracture,</p>
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	<p>or traumatic arthritis secondary to on-the-job injury to the affected joint:</p> <p>1. Conservative Care: Immobilization, which may include: Casting, bracing, shoe modification, or other orthotics. OR Anti-inflammatory medications. PLUS:</p> <p>2. Subjective Clinical Findings: Pain including that which is aggravated by activity and weight-bearing. AND Relieved by Xylocaine injection. PLUS:</p> <p>3. Objective Clinical Findings: Malalignment. AND Decreased range of motion. PLUS:</p> <p>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.</p> <p>Procedures Not supported: Intertarsal or subtalar fusion, except for stage 3 or 4 adult acquired flatfoot.</p> <p>(Washington, 2002) (Kennedy, 2003) (Rockett, 2001) (Raikin, 2003)</p> <p>For average hospital LOS if criteria are met, see Hospital length of stay (LOS).</p>
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<p>Hospital length of stay (LOS)</p>	<p>Recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. For prospective management of cases, median is a better choice than mean (or average) because it represents the mid-point, at which half of the cases are less, and half are more. For retrospective benchmarking of a series of cases, mean may be a better choice because of the effect of outliers on the average length of stay. Length of stay is the number of nights the patient remained in the hospital for that stay, and a patient admitted and discharged on the same day would have a length of stay of zero. The total number of days is typically measured in multiples of a 24-hour day that a patient occupies a hospital bed, so a 23-hour admission would have a length of stay of zero. (HCUP, 2011)</p> <p>ODG hospital length of stay (LOS) guidelines:</p> <p>Ankle Fusion (<i>icd 81.11 - Ankle fusion</i>) Actual data -- median 2 days; mean 2.8 days (± 0.1); discharges 6,892; charges (mean) \$37,465 Best practice target (no complications) – 2 days</p> <p>Triple Arthrodesis (<i>icd 81.12 - Triple arthrodesis of foot and ankle</i>) Actual data -- median 2 days; mean 2.6 days (± 0.1); discharges 4,271; charges (mean) \$37,130 Best practice target (no complications) -- 2 days</p> <p>Subtalar Fusion (<i>icd 81.13 - Subtalar fusion</i>) Actual data -- median 2 days; mean 2.7 days (± 0.3); discharges 1,294; charges (mean) \$31,840 Best practice target (no complications) -- 2 days</p>
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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)**