



Claims Eval

Notice of Independent Review Decision

July 26, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Right Second Metatarsal Osteotomy, Plantar Plate Repair, and Possible Second Metatarsal Head Excision between 6/3/13 and 8/2/13.

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

American Board of Orthopaedic Surgery

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 medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- 6-21-10, surgery.
- 11-16-12, office visit.

- 12-11-12, Peer Review.
- 4-3-13, office visit.
- 5-8-13, injection.
- 5-28-13, office visit.
- 5-31-13, Medical Review.
- 6-6-13 Medical Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

6-21-10, preoperative and postoperative diagnosis:

1. Right traumatic bunion deformity, right second metatarsophalangeal joint degenerative joint disease with loose bodies. Procedure: Right traumatic bunion deformity correction with claimant chevron osteotomy and distal soft tissue. Right savored metatarsophalangeal joint arthrotomy with extensive debridement and excision of loose bodies.

11-16-12, the claimant is here for follow-up of her right forefoot pain. She is having diffuse pain in the forefoot region. She feels like the orthotic is actually making the pain worse. Impression/Plan: Foot, arthritis, posttraumatic, right. The evaluator recommend she try a second MTP steroid injection under radiographic guidance to see if this helps with her pain. She will continue with comfortable shoes and permanent work restrictions.

12-11-12, performed a Peer Review. It was his opinion after reviewing the mechanism of Injury, the multiple medical records available for review, and the peer-reviewed evidence-based Official Disability Guidelines Shoulder Chapter, updated 11-29-12, the current treatment has been reasonable and necessary for this very complex shoulder injury followed by multiple post-surgical problems. As you know, only a treating physician or Designated Doctor- Evaluation can determine the ability to return to work with restrictions. This injured employee has had numerous shoulder surgeries and multiple dislocations of the right shoulder. In all medical probability, the injured employee should be able to return to sedentary duties with no use of the right shoulder. After reviewing the medical documentation presented for review and the peer-reviewed evidence-based medical literature., in all medical probability, the injured employee is at high risk for right shoulder spontaneous dislocation. As with all major surgical procedures, complications can occur. Complications associated with shoulder replacement include infection, loosening, dislocation, and nerve or blood vessel injury. Based on the medical documents presented for review and the peer-reviewed: evidence-based Official Disability Guidelines Shoulder Chapter, updated 11-29-12, the injured employee will require

lifetime care for the compensable injury. The Official Disability Guidelines would support the injured employee following with the treating physician every six months. The injured employee will require occasional x-rays to document the status of the reverse shoulder prosthesis. No further ref trek, durable medical equipment, therapies, work hardening, work conditioning, chiropractic treatment, or injections would be supported as medically necessary. The continued use of Tramadol, which is a synthetic opioid pain medication, would be supported with documentation of increased function and decreased pain. At this point in time for the compensable Injury, no further surgery would be supported, but if the injured employee: undergoes another spontaneous dislocation, a manipulation under anesthesia would be supported as reasonable and necessary.

4-3-13, the claimant is here for follow-up of her right forefoot. She had many months of pain relief from her right second MTP joint injection, but the pain returned. She tried to get another steroid injection, but apparently this was denied. She has also noticed that her third toe is starting to dorsiflex. She has been having pain at the dorsal aspect of the third toe PIP joint with shoe-wear. Impression/Plan: Foot, arthritis, posttraumatic, right. The evaluator will try to get her another second MTP steroid injection. She will tape the toe to try to relieve pain.

5-8-13, procedure performed: Fluoroscopically guided right 2nd MTP joint steroid injection. After informed consent was obtained a 25-gauge needle is inserted into the right 2nd MTP joint under fluoroscopic control using sterile technique. 0.5 mL of Isovue-300 is instilled into the joint. This is followed by injection of 2 mL of Kenalog 40 mg/ml and 0.5 mL, of Lidocaine. The claimant tolerated the procedure well.

5-28-13, the claimant is here for follow-up of her right forefoot. She had a 2nd MTP steroid injection under radiographic guidance on 5-7-13. She denies any significant relief of her pain from the injection. X-rays were taken of the right foot. 2 views were obtained. The severe degenerative changes are seen at the second MTP joint. The third hammertoe deformity is noted. There is good correction of the bunion deformity. Impression-Plan: Foot, arthritis, posttraumatic, right. The evaluator went over the findings at length with the claimant and her husband. The evaluator talked about this difficult problem. She is clearly not responding to nonoperative management. The evaluator talked about a second metatarsal osteotomy with plantar plate repair. The evaluator also talked about a possible second metatarsal head excision and/or interpositional arthroplasty if indicated. The risks and benefits of the planned forefoot surgery were discussed at length with the claimant.

5-31-13, performed a Medical Review. It was his opinion that the clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The mechanism of injury was not specifically stated. The claimant's medication regimen includes ibuprofen, Darvocet, Norco 10-325 mg, Voltaren gel, and Lidoderm patch. Surgical history included right shoulder replacement, left shoulder replacement, and right forefoot surgery. Other therapies include injections to the right foot on 11-30-12 and 5-8-13. The request for 1 Right Second Metatarsal Osteotomy, Plantar Plate Repair, and Possible Second Metatarsal Head Excision is

non-certified. The clinical documentation submitted for review evidences the claimant continues to present with right forefoot pain complaints status post a work-related injury in 9-08 and subsequent surgical interventions. The clinical notes do not evidence what surgical procedure the claimant underwent to the right forefoot. The provider documents the claimant has received 2 steroid injections to the right forefoot, with the second one having provided her no significant relief of her pain. The clinical notes do not evidence the claimant has utilized recent supervised therapeutic interventions or orthotics for her pain complaints to her right foot. Given the lack of documentation submitted for review in support of the current request, the request for 1 Right Second Metatarsal Osteotomy, Plantar Plate Repair, and Possible Second Metatarsal Head Excision is non-certified.

6-6-13, performed a Medical Review. It was his opinion that the request for right second metatarsal osteotomy with plantar plate repair and possible 2nd metatarsal head excision is not recommended as medically necessary based on the clinical documentation submitted as well as current literature recommendations. This is an appeal of a prior denial in which the previous reviewer opined that there were no recent supervised therapeutic interventions or orthotics for the right foot. The claimant underwent a right traumatic bunion deformity correction with right 2nd metatarsal phalangeal joint arthrotomy and extensive debridement in 6-10. The claimant has undergone a recent steroid injection to the 2nd metatarsal on 5-8-11. The claimant's exam findings demonstrated continued tenderness of the right 2nd metatarsal phalangeal joint with laxity to anterior drawer testing. Radiographs were stated to show degenerative changes at the 2nd metatarsal phalangeal joint with a 3rd hammer toe deformity. The clinical documentation submitted for review did not address the prior reviewer's concern as there was no other documentation regarding therapeutic interventions or use of orthotics that has failed to improve the claimant's current complaints. Without further information regarding an exhaustion of conservative treatment prior to consideration for surgery, medical necessity would not be established at this time.

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

The request for right second metatarsal osteotomy with plantar plate repair and possible 2nd metatarsal head excision is not recommended as medically necessary based on the clinical documentation submitted as well as current literature recommendations. Claimant had prior bunion surgery in June 2010. There is no documentation of attempts to use of orthotics or other non-surgical methods. Therefore, the request for 1 Right Second Metatarsal Osteotomy, Plantar Plate Repair, and Possible Second Metatarsal Head Excision between 6/3/13 and 8/2/13 is not reasonable or medically necessary.

Wheeles Textbook of Orthopedics: Chevron Osteotomy

Indications:

- for younger patients w/ no joint arthrosis, and w/ mild to moderate hallux valgus deformities (IM angle less than 16 and MTP less than 30-35 deg);

- this might be the procedure of choice for young athletes;

- elderly patients might not do as well w/ this procedure;

- requirements:

- for pts younger than 50 yrs w/ minimal to moderate deformity;

- pt should have a congruent joint;

- deformity should be passively correctable;

- contraindications:

- significant degree of pronation of the great toe (since this deformity will not be corrected w/ a chevron osteotomy);

- MTP angle > 30-35 deg

- IM angle > 16 deg

- distal metatarsal articular angle of more than 15 deg;

- a Chevron performed on a more excessive angle may cause the 1st MTP joint to impinge on the second MTP joint;

- tight adductors:

- if adductor tightness will require an adductor tenotomy, then a proximal metatarsal osteotomy should be chosen over the chevron (due to preservation of the metatarsal head blood supply);

- incongruent MTP joint;

- relative contra-indications:

- severe displacement of sesamoids;

- older patients

The foot surgery atlas: Hallux valgus, basal osteotomy

Operative indications:

A basal osteotomy can be used as personal preference dictates to some extent.

More often it is used for severe Hallux valgus deformities with IM angles in excess of 20 degrees. Using a basal opening wedge for the osteotomy as described here will always have the effect of making the distal metatarsal articular angle more valgus. This may increase the tendency for the hallux itself to angle laterally. It is easily counteracted by an Akin osteotomy, which is an acceptable price for the increased potential correction of the intermetatarsal angle over diaphyseal osteotomies. Non opening wedge basal osteotomies do not carry this issue with them. The simplicity and reproducibility of the Arthrex basal plate however merits its serious consideration for this procedure.

The upper limit of its use, after which consider acute corrective MTP fusion with lateral release, is 26-28 degrees

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): Wheelles Textbook of Orthopedics, Foot surgery atlas.