



Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 8/28/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of left foot removal of painful hardware and possible arthrodesis left foot with bone graft.

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

The reviewer is a Medical Doctor who is board certified in orthopedic 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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of left foot removal of painful hardware and possible arthrodesis left foot with bone graft.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed:

- Office Note – 7/23/13
- Medication Management Reports – 4/2/13, 5/2/13
- Orthopedic Report – 10/9/09, 1/14/10, 2/11/10, 3/25/10, 5/6/10, 9/14/10, 10/26/10, 11/22/10, 1/14/11, 4/12/11, 4/26/11, 6/6/11, 7/21/11, 8/30/11, 10/21/11, 12/6/11, 12/22/11, 3/9/12, 7/19/12, 9/13/12
- Addendum – 12/20/10
- Manual Muscle Strength Exam Ankle – 1/4/13, 2/15/13

X-Ray Script – 10/9/09, 1/14/10, 2/11/10, 3/25/10, 5/6/10, 9/14/10,
10/26/10

Surgery Reservation Sheets – 10/20/09, 12/18/09

Peer Review Reports – 10/25/10, 12/29/10, 10/14/11

Peer Review Cover Letter – 10/20/11

Decision/Order Notice – 6/18/10

Notification of Scheduling Benefit Contested Case Hearing – 4/16/10

SOAP Note – 9/9/09

Office Note – 7/24/09

Initial Exam – 7/15/09

Initial Examination – 3/13/09

Pre-authorization Approval Letter – 10/21/09, 11/13/09, 1/4/10, 2/3/11,
3/18/11, 10/8/12

Denial Letters – 11/29/11, 7/30/12

Lab Report – 6/4/12

Fluoro Ortho Report – 4/7/11

Posting Sheet – 3/30/11

Operative Report – 1/6/10

MMT and ROM Report – 10/9/09

Records reviewed

Denial Letters – 2/15/13, 3/5/13

LHL009 – 3/12/13

DWC73

Surgery Reservation Sheet – 2/11/13

Orthopedic Report – 1/4/13, 2/15/13

Bone Scan Report – 12/10/12

Left Foot CT – 3/2/12

Imaging Report – 12/27/10

Left Foot CT – 6/25/09

X-ray report – 3/16/09

Operative Reports – 1/6/10, 4/6/11

Denial Report – undated

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injury was noted to relate to the claimant having foot fractures. A drug usage history was noted. Clinical provider records (as of 7/23/13 and prior) revealed that there was persistent foot pain, a surgical scar, swelling tenderness and a diagnosis of closed left foot 1st metatarsal/tarsometatarsal joint fracture/dislocation and multiple metatarsal fractures.. The claimant was noted to be status post revision arthrodesis of the left tarsometatarsal joint with painful hardware. An antalgic gait was also noted. Treatments have included immobilization, therapy and medications along with the prior surgery. Infection was noted to be unlikely based on a work-up and “extensive osteoarthritic change” was noted in the 1st tarsometatarsal joint. A 7/19/12 dated noted discussed a non-union of revision fusion on CT scan. The 12/27/10 dated CT scan revealed a left foot fracture nonunion. The 3/2/12 dated CT scan report revealed OA of the 1st tarsometatarsal joint with retained hardware. Denial letters discussed the lack of definitive symptoms from either the hardware or a nonunion.

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

The claimant has symptomatic painful hardware that has resulted in swelling and an antalgic gait. There has been documented evidence of at least osteoarthritis of the 1st tarsometatarsal joint. With retained hardware the evidence of a nonunion has not been able to be fully elucidated. The claimant has failed reasonable non-operative treatment with regards to the retained hardware and possible nonunion of the foot fracture dislocation-revision arthrodesis. Therefore at this time the request is medically necessary in order to remove the probable pain generator and to address any residual nonunion.

ODG Foot/Ankle Chapter:

Hardware Removal: 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, re-fracture,

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-centered outcomes. (Hanson, 2008)

Arthrodesis: 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.

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, except for stage 3 or 4 adult acquired flatfoot.

(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)**