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Notice of Independent Review Decision

[Date notice sent to all parties]:

11/26/2014

IRO CASE #:

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: appeal OP left foot
internal fixation screw removal 20680**

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

Board Certified Orthopedic Surgeon

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a male who had a history of an injury to the left lower extremity. He was admitted to the hospital and had a fracture of the right hip acetabular rim with minimal displacement. His left ankle x-rays were considered normal. He has a crush injury in the foot with significant swelling and there was bony injury to the foot. He had fractures of the distal 2nd and 3rd metatarsals with displacement of the 3rd, 4th, and 5th metatarsals with fractures. He has a Lisfranc type fracture dislocation of the tarsal metatarsal joint of the 2nd and 3rd metatarsals. He was taken to surgery on 05/01/14 and had open reduction and internal fixation of the Lisfranc fracture dislocation of the left mid-foot that was performed. On 09/23/14, this patient was seen for follow up on his left foot, and deep tendon reflexes were 2+ and symmetrical, and his wounds had well-healed. He was having minimal pain. His physical therapy was going well and he was working hard obtaining good range of motion of his ankle. It was noted that he had internal fixation screws in a lateral aspect of the foot that limited mobility in range of motion. Removal of those screws was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS,

FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The submitted records indicate that this request has been reviewed on 09/30/14, and it was noted that the request was non-certified. It was noted there was no documentation of a nonunion or rule out of a nonunion and there was no evidence of broken hardware or possible infection to remove the hardware. A subsequent 10/21/14 notification of reconsideration determination also noted that routine hardware explantation is not recommended. It was noted that there was no evidence of a fracture or malunion or nonunion of the left foot, and it was noted the patient was having minimal pain and objective quantitative measurements of the ankle were not provided. The submitted records indicate this patient does have hardware placed in the left ankle as of 05/01/14. It was noted that on 09/23/14 that the patient should have the hardware removed to increase range of motion of the foot and ankle. A physical therapy note on 10/01/14 indicated this patient had no impairment as far as moving and handling objects, and he had 10 degrees of active range of motion and dorsa flexion of the left foot and ankle with knee flexed, 50 degrees of plantar flexion, 17 degrees of eversion, and 45 degrees of inversion. The records do not indicate there is a question of infection or a question of a nonunion of this fracture. There is no evidence that the hardware itself is broken and there is no evidence that the hardware is impeding range of motion at this time. The recommendation is for non-certification of this request and upholding the previous determinations.

IRO REVIEWER REPORT TEMPLATE -WC

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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. (Hanson, 2008)