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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 2, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed right ankle hardware removal status post open reduction internal fixation (20680, 20902)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
996.4	20680		Prosp	1			Xx/xx/xx	xxxxx	Overturned
996.4	20902		Prosp	1			Xx/xx/xx	xxxxx	Overturned

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a gentleman who was seen with a history of injuring his right ankle. Subsequent x-rays were consistent with a bimalleolar fracture. The medial malleolus was displaced and there is evidence of ankle mortise disruption of the talus laterally displaced in relation to the tibial plafond. A close reduction was done and the patient was placed in some type of cast. There was continued lateral subluxation of the talar dome in relation to the tibial plafond and mildly displaced fractures of the distal fibula and medial malleolus.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

The patient was subsequently seen. On 4/11/13, X-rays at that time determined that the patient continued to have displacement and there was some evidence of healing. On 4/15/13 the patient had surgery to repair a right distal fibular malunion and repair of the distal tibial malunion. On 6/7/13, a syndesmosis screw was removed. The patient improved; however, he continued to complain of some pain. During this time, the patient was also treated with physical therapy. On xx/xx/xx, the patient slipped on some ice and twisted the right ankle. He had been using a cane to assist ambulation. Previously, when seen on 11/11/13, and the fracture appeared to be largely healed. Because of the pain, a steroid injection was done into the joint space . On 3/20/14, a physical examination on the ankle revealed exquisite tenderness over her distal fibula, slight tenderness to the medial malleolus and diffuse swelling.. There was no evidence of joint instability. A steroid injection into the intra-articular space was recommended. It was noted also that the patient is still using a cane to assist ambulation and still have a lot of pain in the lateral and anterior right ankle. Most of the pain was noted to be in the lateral ankle and deep into the joint. There was noted to be tenderness laterally over the plate and some medial tenderness over the head of the medial screws.

It was felt that hardware removal should be done. While it was also felt that this would not necessarily control all of his pain, to the extent that the hardware was part of the problem, it should be removed.

Based upon **ODG**, and the findings documented in the notes provided for review, the request for removal of the hardware is indicated and medically necessary.

ODG

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](#))

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

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES