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DATE: 4/7/16

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OP Lt Ankle Fibular Osteotomy Hardware Removal w/Fusion

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

The reviewer is a Board Certified Orthopedic Surgeon with over 18 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adversedeterminations 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]:

The claimant is a gentleman that fractured his left ankle on XX/XX/XX while at work climbing a ladder to clean grain screen on a mixer and fell.

XX/XX/XX: 3 view x-ray of left foot. Impression: 1. No acute radiographic abnormality of the foot. 2. Comminuted fracture dislocation at the ankle.

XX/XX/XX: 4 view x-ray of left tib/fib and 3 view x-ray of left ankle. Impression: Comminuted fracture-dislocation of the left ankle with lateral dislocation of the talus.

XX/XX/XX: 3 view x-ray of left elbow. Impression: No acute radiographic abnormality.

XX/XX/XX: Operative report: Procedure: 1. Closed reduction, left ankle dislocation. 2. Application of multiplanar external fixator, left lower extremity. 3. Application of posterior splint. 4. Intraoperative fluoroscopy. Postoperative diagnosis: 1. Left ankle dislocation. 2. Left distal tibia fracture with fibula fracture.

XX/XX/XX: CT of the left foot and ankle without contrast. Impression: Minimally comminuted fracture through the anterior and posterior lateral aspect of the distal tibia extending to the tibial plafond. There is mild residual anterior subluxation of the talus. 2. Acute transverse fracture of the medial malleolus with mild lateral talar shift.

XX/XX/XX: Operative report. Procedure performed: 1. Open reduction and internal fixation of left pilon fracture. 2. Open reduction and internal fixation of left fibular fracture. 3. Removal of hardware, removal of external fixation, left lower extremity. 4. Intraoperative fluoroscopy. 5. Application of posterior splint, left lower extremity. Postoperative diagnosis: 1. Left pilon fracture. 2. Left fibular fracture.

XX/XX/XX: Progress report states that patient has been weight bearing as tolerated in the boot. He has been using the bone stimulator twice daily as directed. He states that he is still having pain and swelling but it is tolerable. X-rays of the foot and ankle were taken today revealing once again little trabeculation across the medial malleolus, however, the hardware is still in place. Nonunion malleolar fracture, which appears to be stable at this time. He will be released back on light duty. It was explained to him that we have exhausted all conservative measures. He is advised that if hardware starts to loosen, then he may need a revision of the medial malleolus. I will see him back in four weeks

XX/XX/XX: PR states that patient states he is doing okay. He is back in normal shoe gear. He still uses bone stimulator at night. He does wear his ankle brace, which he states makes him feel better. On physical examination there is some pain on palpation to the anteromedial gutter. Minimal discomfort of the medial malleolar fracture. X-rays taken today again show a very little trabeculation across the medial malleolus fracture. There are early arthritic changes noted along the ankle joint. Remainder of the fracture appeared to be stable with hardware intact. He is back in light duty. I will see him back in four weeks.

XX/XX/XX: PR states that patient is still having some discomfort in the left ankle. He is still having some pain and swelling. He states that he is still not ready to go back to full duty. Today, there is a significant amount of pain in the anterolateral and anteromedial gutters of the ankle. Minimal discomfort of the medial malleolar fracture. X-rays taken today again show a very little trabeculation across the medial malleolus fracture. There are early arthritic changes noted along the ankle joint. It appears he has significant pain in his ankle likely to secondary to his synovitis and arthritis. Today, an arthrocentesis was performed. We will see how he does with this injection and see him back in two weeks. We will also ass an anti-inflammatory to see if this will help.

XX/XX/XX: PR states patient say last injection helped and he feels about 40% better. There is still palpable discomfort of the anteromedial and anterolateral gutters of the ankle. It has slightly improved since his last visit. Today another arthrocentesis was performed and I will see him back in four weeks to reevaluate.

XX/XX/XX: PR states that the last arthrocentesis injection did help the patient for a couple of weeks. He states he still has some pain and discomfort. He states that he believes the pills are helping. 3 view x-ray of the ankle was taken today and revealed early osteoarthritic changes in the left ankle. Stable nonunion malleolus with hardware intact. It was explained to the patient that he had a very bad fracture and it is normal to see some arthritic changes. He will continue meloxicam and come back in about 8 weeks to reassess.

XX/XX/XX: PR states patient is still having some pain and discomfort. He thinks meloxicam is no longer helping. He states that he had a lot of discomfort this week with the cold weather. He also states a lot of stiffness. Once again, he states the discomfort in the anterolateral and anteromedial gutters. Some crepitation noted with dorsiflexion and plantar flexion of the left ankle joints. Clinically, once again, he has a high cavus type of foot structure. X-rays again show arthritic changes with slight valgus deformity. Today, it appears his arthritis is becoming more symptomatic. It was explained to him that I believe he will not benefit from an ankle arthroscopy due to him already having bone on bone arthritis. At this point, I am recommending an ankle fusion. At the same time we do the fusion, we will also evaluate his medial malleolus inoperatively to assure that it is properly healed. The patient still does has some symptoms there, but appear to be minimal. We will try to get this authorized.

XX/XX/XX: PR states patients is not doing well. He states his Meloxicam is no longer working, he has pain with the weather changes, still has swelling, he still feels a lot of stiffness. Once again, he states the discomfort in the anterolateral and anteromedial gutters. Some crepitation noted with dorsiflexion and plantar flexion of the left ankle joints. Clinically, once again, he has a high cavus type of foot structure. X-rays again show significant arthritic changes with slight valgus deformity. The patient has failed conservative treatments including oral anti-inflammatories and bracing. He has significant arthritis due to his previous fracture. I am recommending once again the ankle fusion. We will perform a fibular osteotomy and remove the previous hardware. We will evaluate the medial malleolus nonunion intraoperatively due to his equines. He may possibly need a gastrocnemius recession. We will submit for

authorization.

XX/XX/XX: UR. Rationale: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. While the patient complains of left ankle pain, there was no evidence in the medical reports submitted that the patient has exhausted conservative management including physical therapy prior to the proposed surgery.

XX/XX/XX: UR. Rationale: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. There was no documentation the patient's pain was relieved by xylocaine injection.

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

The previous adverse decision is upheld. The request for ankle fusion with fibular osteotomy is denied.

The patient sustained a fracture-dislocation of the left ankle in XX/XX/XX. He underwent open reduction internal fixation of an intra-articular (pilon) ankle fracture. He now has significant ankle pain. His treatment has included bracing and NSAIDs. He has had temporary pain relief following an intra-articular ankle injection. His recent radiographs demonstrate advanced arthritic changes in the ankle joint. He may also have a non-union of his medial malleolus fracture.

The Official Disability Guidelines (ODG) supports ankle fusion for the treatment of traumatic arthritis of the ankle. Prior to surgery, the patient should complete a course of conservative care. Subjective and objective clinical findings should also be consistent with ankle arthritis.

This patient is not a surgical candidate at the present time. He has not met all of ODG criteria such as, he has not had a trial of orthotics or shoe modification and he has not completed a course of physical therapy. A full course of physical therapy should be completed before considering an ankle fusion with possible gastrocnemius recession for equinus contracture.

A CT scan would also be recommended based on ODG criteria 4 to determine whether the patient has healed his medial malleolus fracture. The patient may require a bone stimulator to treat this potential non-union, before moving forward with additional surgery. The CT scan would also provide information on the condition of the adjacent subtalar and talonavicular joints.

The proposed OP Lt Ankle Fibular Osteotomy Hardware Removal w/Fusion is not medically necessary at the present time.

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)**