

March 12, 2018

Amended: June 21, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Open reduction internal fixation (ORIF) left fifth metatarsal

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

Orthopedic Physician

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X 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 patient is a XXXX who was injured on XXXX, when XXXX sustained an inversion-type injury to XXXX left foot while walking on uneven ground. XXXX continued work but developed pain and swelling.

Per Patient Referral dated XXXX, the patient was seen at XXXX by XXXX. The diagnoses were other abnormalities of gait and mobility, unspecified fracture of the left foot, nondisplaced fracture of a fifth metatarsal bone of the left foot and unspecified sprain of the left foot. XXXX referred the patient for physical therapy (PT).

On XXXX, an authorization request for six sessions of therapy was documented.

On XXXX, XXXX, evaluated the patient at XXXX. It was noted that the patient was seen at XXXX and was found to have a fifth metatarsal fracture. XXXX was placed in a boot. XXXX was taking XX for pain but continued to have pain. The past medical history was notable for hypertension and diabetes. XXXX medications were listed as XXXX. On exam, the patient ambulated on XXXX left lower extremity in a boot. XXXX had swelling and tenderness at the fifth metatarsal base region. The skin was intact. There were no gross deformities. XXXX was able to dorsiflex and plantarflex the ankle and toes. There were good distal pulses. X-rays of the left foot showed a nondisplaced fracture at the proximal diaphyseal-metaphyseal junction of the fifth metatarsal. XXXX diagnosed left fifth metatarsal fracture, Jones type. XXXX was worried about the healing due to diabetes. XXXX discussed the surgical treatment for more predictable healing of the patient's fracture. In the meantime, the patient was advised to continue XXXX boot, pain medication and work restrictions.

On XXXX, XXXX submitted a preauthorization request for ORIF of the left fifth metatarsal fracture.

On XXXX, a correspondence from XXXX notified the patient that the request for ORIF of the left fifth metatarsal was denied based on the following rationale: *“Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced (ORIF is recommended as an option for fractures when radiographic evidence indicates a displaced fracture or comminuted fracture, or an open fracture with a bone protrusion.), this request is non-certified. There was limited documentation of significant objective findings that would validate the need for surgery. Given the conflicting information regarding whether or not the fracture is displaced or non-displaced and without an actual radiology report, the request is not supported at this time.”*

A correspondence dated XXXX, notified the patient that upon reconsideration, the denial for ORIF of left fifth metatarsal was upheld. 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. The provided documentation still did not include the actual radiologist report and XXXX description of the radiograph indicates the fracture is nondisplaced. The patient’s injury was approximately 5 weeks ago thus does not meet the formal definition of nonunion. There is incomplete documentation of failure of conservative treatment such as immobilization. Furthermore the guidelines specifically note nonoperative treatment remains a viable alternative to surgery in all acute and delayed cases, providing there is no established nonunion and the patient is aware of the implications (in the athletic individual there may be an advantage for surgery in terms of time to return to sporting activity). The guidelines also note nonoperative treatment is indicated in Torg I fractures, such as this. I did ask to speak with XXXX several times; however, XXXX indicated XXXX was able to perform the peer to peer. No additional information was garnered during this discussion. Based on the guidelines, the previous non-certification will be upheld. Thus, the request is not medically necessary.”*

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

Articles and arguments can be found in the orthopaedic and podiatric literature favoring early surgical intervention as well as nonsurgical management in Torg Type I Jones fractures. Most studies do not meet NOT Level I criteria study criteria. Thus, controversy remains.

That acknowledged, ODG is the primary source for evidence-based recommendations in XX, as approved by the XXXX. ODG does NOT recommend early surgical intervention for Torg Type I (nondisplaced) Jones fractures. The information presented to the previous two reviewers appears to demonstrate evidence that the fracture in this case is nondisplaced. Thus, surgery is not recommended per ODG. A compelling case for treatment outside ODG recommendations has not been produced by the surgeon. Thus, the disapproval of the surgery request by the two previous reviewers appears to be reasonable and within ODG criteria.

Per ODG: Jones Fracture (surgery):

Not recommend surgery except for Torg type III (nonunion fractures or significantly displaced).

See also [Surgery for Morton's neuroma](#).

A Jones fracture is a fracture of the fifth metatarsal of the foot, at the base of the small toe. If a Jones fracture is not significantly displaced, it can be treated with a cast, splint or walking boot for four to eight weeks. Nonoperative treatment remains a viable alternative to surgery in all acute and delayed

cases, providing there is no established nonunion and the patient is aware of the implications (in the athletic individual there may be an advantage for surgery in terms of time to return to sporting activity). (Dean, 2012) Bandaging is superior to below knee cast immobilization for patient-reported functional and pain scores, with no difference in fracture union or re-fracture, and a shorter duration for return to work. (Smith, 2011)

Of all foot fractures the fifth metatarsal fracture is the most common. The indication for surgical treatment of Jones' fractures depends on activity level and Torg classification: type I fractures are treated non-operatively. Type II fractures can be treated non-operatively or operatively, depending on patient activity level. Type III fractures have more complications and should be treated operatively. (Zwitser, 2010)

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Medically Necessary

Not Medically Necessary

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES