

Case Number:	CM13-0030250		
Date Assigned:	11/27/2013	Date of Injury:	01/23/2012
Decision Date:	01/31/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/30/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Podiatric Surgery and is licensed to practice in New York. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the enclosed documentation this patient sustained an ankle injury in late 2012. She was diagnosed with an osteochondral defect of the talus and underwent ankle arthroscopy on 1-25-2013. PT continued to have pain to the right ankle, and on 6-14-2013 she underwent right ankle stabilization and ligament repair surgery. Roughly a month s/p repair she was diagnosed with an infection and placed on oral antibiotics. AN MRI performed on 7-25-2013 demonstrated possibility of infection to the joint. On 8-2-2013 she underwent surgical debridement of necrotic tissue down to bone, decompression of lesser saphenous nerve, and advanced closure. She was placed on oral antibiotics. On 8-16-2013 she was seen by her podiatrist on an emergency basis for continued infection. Her oral antibiotics were changed. On 8-18-2013 she visited the ED where she was seen by a different podiatrist. She advised him of her past medical and surgical history, and advised that she walked on the right ankle surgical area too much as well as removed the surgical dressings prematurely. At this point she was admitted to the hospital, place on IV antibiotics, and scheduled for another I and D of the right ankle for 8-19-2013.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

RETROSPECTIVE ER ADMIT, DATE OF SERVICE 8/18/13: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Hugar DW. Management of infection. In: Marcus SA, Block BH, eds. American College of Foot Surgeons: complications in foot surgery: prevention and management, 2nd ed. Baltimore: Williams & Wilkins, 1984:494-502; Miller WA. Postoperative wound infection in foot and ankle surgery. Foot Ankle 1983; 4:102-104; Stapp MD, Taylor RP. Edema, Hematoma, and Infection. In: Banks AS, Downey MS, Martin DE, Miller SJ, eds. McGlamry's Comprehensive Textbook of Foot and Ankle

Decision rationale: MTUS guidelines do not advise on the specifics of this case. The crux of this case deals with the decision of the ED physician to admit the pt. The pt presents with nausea and drainage from the surgical wound. She has a know history of cellulitis to the surgical wound that for the past week or so had not responded to oral antibiotics. The patient was in pain to the surgical area. I feel that the decision to admit this patient for IV antibiotics and an incision and drainage (I and D) was correct and medically necessary. The following excerpt is from a textbook of surgery (Townsend: Sabiston Textbook of Surgery, Chapter 15).Note that the excerpt advises that IV antibiotics and an I and D are recommended for post op surgical wounds that present like the pt in this case, both of which require hospital admission. Townsend: Sabiston Textbook of Surgery, 18th ed. CHAPTER 15- Surgical Complications. Once a surgical site infection is suspected or diagnosed, management depends on the depth of the infection. For both superficial and deep surgical site infections, skin staples are removed over the area of the infection, and a cotton-tipped applicator may be easily passed into the wound with efflux of purulent material and pus. The wound is gently explored with the cotton-tipped applicator or a finger to determine whether the fascia or muscle tissue is involved. If the fascia is intact, debridement of any nonviable tissue is performed, and the wound is irrigated with normal saline solution and packed to its base with saline-moistened gauze to allow healing of the wound from the base anteriorly and prevent premature skin closure. If widespread cellulitis is noted, administration of IV antibiotics must be considered. However, if the fascia has separated or purulent material appears to be coming from deep to the fascia, there is obvious concern about dehiscence or an intra-abdominal abscess that may require drainage or possibly a reoperation.