

Case Number:	CM13-0053731		
Date Assigned:	12/30/2013	Date of Injury:	08/12/2011
Decision Date:	03/20/2014	UR Denial Date:	11/05/2013
Priority:	Standard	Application Received:	11/18/2013

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 Orthopedic Surgery and is licensed to practice in Texas. 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:

The patient is a 51-year-old male who reported injury on 08/12/2011. The mechanism of injury was noted to be the patient tripped over a door jamb and fell landing on both knees. The patient has had physical therapy, a left tibial osteotomy on 05/24/2012 and a removal of hardware on 03/04/2013, followed by a left total knee replacement on 06/12/2013. The most recent x-ray on 10/16/2013 revealed the patient had a slow healing of the osteotomies of the mid to distal shaft of the tibia and fibular diaphyseal fracture with evidence of healing. The most recent office note indicated the patient had persistent pain at the left distal tibia clamshell osteotomy nonunion site. It was indicated that the patient was largely asymptomatic when he underwent the knee arthroplasty but has increasingly severe distal tibial pain and as such the physician opined an additional procedure would be necessary to try to get site at the distal end of the clamshell osteotomy to heal. The patient was noted to be limited in daily activities and experienced daily pain and edema and it was indicated the patient had elected to have surgery to compress the fracture site. The examination of the left lower extremity demonstrated several well-healed incisions without any evidence of active or dried drainage. The patient had 5/5 strength. The tibia was tender to palpation at the distal aspect of the clamshell osteotomy incision and there was mild to moderate pitting edema distal to the incision. The x-rays obtained on that date of 10/17/2013 demonstrated a persistent nonunion of the clamshell osteotomy site distally and had not shown evidence of interval callus formation on serial radiographs. The patient's diagnosis was noted to be pain in joint. The request was made for a right femur bone graft harvest using the RIA system and a posterior approach to the tibia for bone grafting and compression plating.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inpatient surgery left tibia non-union fixation, right femur reamer, irrigator, aspirator, inpatient 1-2 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, ORIF, Hospital Length of Stay

Decision rationale: ACOEM Guidelines indicate surgical consultation is appropriate for patients who have activity limitation for more than 1 month and failure of exercise programs to increase range of motion and strength of the musculature around the knee. ACOEM Guidelines do not specifically address nonunion or open reduction internal fixation. Official Disability Guidelines indicate open reduction internal fixation is recommended for fractures when radiographic evidence indicates a displaced fracture of comminuted fracture or open fracture with bone protrusion. The clinical documentation submitted for review indicated the patient had a persistent nonunion of the clamshell osteotomy site distally. There was a lack of documentation indicating the degree of nonunion as there was no measurement given. The surgery would not be supported. The hospital length of stay for a broken tibia fibula is 3 days per Official Disability Guidelines. The request for a hospital stay is not medically necessary as the surgery was not supported. Given the above, the request for inpatient surgery left tibia non-union fixation, right femur reamer, irrigator, aspirator, inpatient 1-2 days is not medically necessary.