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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 4, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Surgical repair of the peroneus brevis tendon, left foot (27691)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
- Board Certified in Orthopaedic Surgery
- Fellow, American Academy of Orthopaedic Surgeons
- Licensed to Practice Medicine in State of Texas

REVIEW OUTCOME

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

⊗ Overturned (Disagree)

Medical documentation supports the medical necessity of surgical repair of the peroneus brevis tendon, left foot (27691)

ODG criteria utilized for the denials

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old female who sprained her left ankle on xx/xx/xx, and then again on xx/xx/xx, while at work.

The patient was seen, who obtained x-rays of the left ankle, which were negative. Dr. assessed grade II ankle strain with attenuation of lateral collateral ligament, placed the patient in an Air-Cast ankle brace for immobilization, and prescribed anti-inflammatory medications.

Magnetic resonance imaging (MRI) of the left ankle revealed mild tenosynovitis about the peroneus brevis tendon and a multilobulated ganglion cyst along the posterior inferior tibial fibular joint.

Dr. administered steroid injection along the course of the peroneus tendon x3. The injections provided significant improvement in her symptoms. She was later placed into a functional foot orthosis and was started on Medrol Dosepak.

In November, the patient returned to Dr. for exacerbation of left peroneal tendinitis after resumption of full duties. She was instructed to continue wearing functional foot orthosis and was prescribed ibuprofen.

MRI of the left ankle was obtained due to symptom exacerbation. It revealed mild peroneus brevis tendinosis with fraying of the deep margin, partial-thickness longitudinal split of the posterior fibers of the peroneus brevis tendon (new since the prior examination), and mild stable peroneus longus and brevis tenosynovitis.

On January 9, 2008, the patient returned to Dr. for persistent pain in her left lateral ankle along the course of the peroneal brevis tendon. Dr. discussed surgery for tendon repair.

On January 18, 2008, request for repair of the peroneal left tendon with screw fixation/anchor was non-authorized. Rationale: *The request is not supported by the submitted medical documentation. The most recent clinical note dated December 12, 2007, indicates that the patient is improving with conservative care. There is no documentation of conservative treatments the patient is receiving and therefore there is no indication that the patient has failed conservative care.* A request for left tendon nerve block was also denied with the following rationale: *The request is not supported by the submitted medical documentation. The treatment plan is unclear as to whether this is a therapeutic injection or meant as a block for the previously requested operative procedure. Given the lack of documentation to substantiate that the patient has failed conservative care, this request is not considered medically necessary.*

On January 24, 2008, Dr. provided a letter of rebuttal stating that the patient had been treated conservatively for greater than six months with multiple steroid injections and oral anti-inflammatory medications. Her symptoms had waxed and waned from 90% improvement to total inability to perform her duties at work secondary to pain. This was a typical response to steroid injection. The patient would benefit from surgical repair of tendon as six months of conservative therapy including almost all modalities available had failed.

On January 29, 2008, Dr. administered a steroid injection into the left lateral ankle along the course of peroneus brevis tendon.

On February 8, 2008, an appeal for the repair of left peroneal tendon was denied with the following rationale: *Records do not reflect lower levels of care to date. Records do no reflect imaging to support the request. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, the request is not indicated.*

On February 12, 2008, Dr. reported that therapy had been denied and the patient had already exhausted conservative therapy which had been started back on June 20, 2007. Dr. recommended continuing the ankle brace and functional foot orthosis.

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

After review of the available medical records regarding Ms., it is apparent that she has a small longitudinal tear of the left peroneus brevis tendon that has failed multiple modalities of conservative treatment over a period greater than six months. The tear is noted on the MRI of 12/11/07 and the symptoms match the diagnosis of peroneus brevis tear with tendinitis. There are no ODG guidelines specifically addressing tears of the peroneus brevis tendon. Thus, previously cited ODG guidelines addressing ankle sprains and instability as justification for denying surgery are not applicable in this case. Surgery is indicated based on peer review articles published the orthopaedic surgery literature. DC Jones states in "Tendon Disorders of the Foot and Ankle" (Journal of the American Academy of Orthopaedic Surgeons, November 1993; 1:87-94),

"In patients with documented tears of the peroneus brevis, conservative treatment is generally unsuccessful. Surgical repair is accomplished through a curved 7-cm incision along the posterior third of the fibula. The competence of the SPR is assessed. The SPR is then opened in such a way that it can be tightened if attenuated. If the split is through the anterior third of the tendon and the smaller portion of the tear is frayed in any way, I excise the anterior third. If the tear is in the middle third and both fragments are without degenerative change, I repair the tendon with buried nonabsorbable suture. If, however, the entire width of the peroneus brevis tendon is involved and there is significant fraying, the degenerated segment of the tendon is excised in toto, and tenodesis of the proximal and distal stumps to the peroneus longus tendon is performed (Fig. 3) Following surgery on the peroneus brevis tendon, the SPR is advanced and imbricated onto a fresh bony bed. If there is associated ankle instability, this should be repaired as well.

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

- ⊗ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ⊗ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ⊗ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

Answers to questions above are based on Official Disability Guide (ODG) guidelines when applicable and the experience of a Board Certified Orthopaedic Surgeon, trained by an Accreditation Council for Graduate Medical Education (ACGME) approved orthopaedic surgery residency program. Additionally, Dr. participates in continuing medical education and maintenance of certification parameters outlined by the American Board of Orthopaedic Surgery (ABOS) and the American Academy of Orthopaedic Surgeons (AAOS). Reference to MMI and determination of impairment, disability, or apportionment is based on the American Medical Association's *Guides to the Evaluation of Permanent Impairment*. Reference to standard of care in the orthopaedic surgery community is based on literature cited in the *Orthopaedic Knowledge Update*, 9th Edition (AAOS, 2008) in addition to any specifically cited journal articles.

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