

Clear Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 10, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left Ankle Scope w/Lateral Ligament Repair

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

M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity exists for Left Ankle Scope w/Lateral Ligament Repair.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 1/15/09, 12/31/08

ODG Guidelines and Treatment Guidelines

Office notes, Dr. , 07/11/08, 08/04/08, 08/26/08, 09/11/08, 09/30/08, 10/21/08, 12/17/08, 01/07/09

Physical therapy note, 08/29/08

MRI LLE, 09/27/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old female with complaints of left ankle pain from xx/xx/xx. Dr. began treating the claimant on 07/11/08 and treated the claimant through 01/07/09 with bracing, physical therapy, antiinflammatory medications, bracing, boot, work restrictions, and medications. The MRI of the left ankle from 09/27/08 showed no obvious tears of the ankle ligaments though sprain was suspected involving the anterior poster talofibular ligaments and talocalcaneal ligaments. The 01/07/09 examination revealed 4/5 strength inversion/eversion/dorsiflexion and plantar flexion, pain with plantar flexion of 45 degrees. Dorsiflexion was to 20 degrees. Drawer test at neutral caused significant tenderness at anterior talofibular ligament and was increased compared to right. Drawer test in patellofemoral was slightly increased compared to the right. Mid crepitus with range of motion was noted at the tibiotalar joint. Dr. has recommended a left ankle scope with lateral ligament reconstruction.

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

The requested left ankle arthroscopy and lateral ligament repair would appear reasonable based on the information provided. The request meets the ODG Guidelines. The claimant has been treated with physical therapy, bracing, and medications, and has ongoing reports of instability. The claimant had findings suspicious for ligamentous pathology by MRI on 09/27/08. The reviewer finds it is medically necessary to perform an arthroscopy and lateral ligament repair based on the information provided and failure of conservative measures to help the claimant. The reviewer finds that medical necessity exists for Left Ankle Scope w/Lateral Ligament Repair.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, foot and ankle

ODG Indications for Surgery™ -- Lateral ligament ankle reconstruction:

Criteria for lateral ligament ankle reconstruction for chronic instability or acute sprain/strain inversion injury:

1. Conservative Care: Physical Therapy (Immobilization with support cast or ankle brace & Rehab program). For either of the above, time frame will be variable with severity of trauma. PLUS

2. Subjective Clinical Findings: For chronic: Instability of the ankle. Supportive findings: Complaint of swelling. For acute: Description of an inversion. AND/OR Hyperextension injury, ecchymosis, swelling. PLUS

3. Objective Clinical Findings: For chronic: Positive anterior drawer. For acute: Grade-3 injury (lateral injury). [Ankle sprains can range from stretching (Grade I) to partial rupture (Grade II) to complete rupture of the ligament (Grade III).¹ (Litt, 1992)] AND/OR Osteochondral fragment. AND/OR Medial incompetence. AND Positive anterior drawer. PLUS

4. Imaging Clinical Findings: Positive stress x-rays identifying motion at ankle or subtalar joint. At least 15 degree lateral opening at the ankle joint. OR Demonstrable subtalar movement. AND Negative to minimal arthritic joint changes on x-ray.

Procedures Not supported: Use of prosthetic ligaments, plastic implants, calcaneus osteotomies.

(Washington, 2002) (Schmidt, 2004) (Hintermann, 2003)

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)