



Notice of Independent Review Decision

**DATE OF REVIEW:** 7/29/09

**IRO CASE #:**

**NAME:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Determine the appropriateness of the previously denied request for right ankle arthroscopy, lateral ankle stabilization.

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

Texas licensed 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 previously denied request for right ankle arthroscopy, lateral ankle stabilization.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Texas Department of Insurance Fax Cover Sheet dated 7/20/09.
- Notice to CompPartners, Inc. of Case Assignment dated 7/20/09.
- Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 7/20/09.
- Medical Documentation Request/Letter dated 7/21/09.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/17/09.
- Request Form/Request for a Review by an Independent Review Organization dated 6/25/09.
- Treatment/Service Request/Letter dated 6/5/09, 5/7/09.
- SOAP Note dated 6/15/09, 4/30/09, 4/23/09.
- Initial Evaluation Report dated 4/23/09.
- Summary of Treatment/Case History Report dated 5/7/09.
- Appeal Discussion Report dated 6/5/09.
- Fax Cover Sheet/Authorization Request dated 5/14/09, 4/30/09.
- Report of Medical Evaluation dated 2/5/09.
- History and Physical Examination Report/Letter dated 2/5/09.
- Texas Workers' Compensation Work Status Report dated 2/5/09, 2/27/09.
- Physical Therapy Daily Note dated 3/12/09, 3/9/09, 3/6/09.
- Status Report: Follow-Up Evaluation dated 2/27/09.
- Billing Procedures Sheet dated 2/27/09.
- Physical Examination Report/Letter dated 2/25/09.

**There were no guidelines provided by the URA for this referral.**

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:**

**Gender:** Male

**Date of Injury:**

**Mechanism of Injury:** Stepped out of his truck and felt a sharp pain in the right ankle.

**Diagnosis:** Ankle sprain and ankle synovitis and chronic lateral ankle instability.

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

The patient is a male with the date of injury of xx/xx/xxxx. The mechanism of injury: Stepping out of his truck onto an uneven surface. The diagnoses were ankle sprain and ankle synovitis and chronic lateral ankle instability. The patient initially was diagnosed with an ankle strain/sprain. The patient gave a history of wearing boots and did not remember rolling or twisting the ankle. The patient had been treated extensively on a conservative basis, has received 21 plus sessions

of physical therapy and has had an injection in the ankle by Dr. that was beneficial. Dr. 's physical examination findings noted pain to palpation and tenderness about the anterior talofibular ligament (ATFL). As of the April 30, 2009 report and more recently on June 15, 2009, again, there was pain on palpation with swelling and tenderness of the right lateral ankle, inversion, stress caused pain along the anterior and lateral ankle, and anterior drawer sign was negative. Anterior talar excursion was normal, indicating anterior drawer being negative. On June 15, 2009, Dr. indicated, due to the patient's failure of extensive physical therapy, steroid injections and a walking boot, he recommended arthroscopy with ankle stabilization if determined necessary at surgery. The prior peer reviewers indicated in their reviews that the surgical procedure was not recommended because the physical examination failed to indicate a torn ligament and the MRI failed to indicate a torn ligament. The rationale for denial at this time, is the patient did not have a demonstrable ligamentous injury to the ankle, either by physical examination or by MRI examination. The ankle itself did not have a pathological condition demonstrated on physical examination nor by MRI examination. Therefore, at this time, the patient would not meet the Orthopedic Knowledge Update on Foot and Ankle Guidelines for Broström repair. The ODG criteria for Ankle Sprain surgery state "*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).<sup>1</sup> (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.*" These criteria are not met and therefore the prior recommendations are upheld.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE.
- AHCPH – 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.

Official Disability Guidelines (ODG), Treatment Index, 7<sup>th</sup> Edition (web), 2009, Foot ankle-“*ODG Indications for Surgery™*”

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).

Orthopedic Knowledge Update