



Notice of Independent Review Decision

**DATE OF REVIEW:** 10/19/09

**IRO CASE #:** **NAME:**

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

Determine the appropriateness of the previously denied request for left ankle scope, left ankle modified Brostrum lateral ligament reconstruction.

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

A 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 left ankle scope, left ankle modified Brostrum lateral ligament reconstruction.

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

1. TDI Check List dated 9/29/09.
2. Fax Cover Sheet/Comments 9/18/09, (unspecified date).
3. Notice to CompPartners, Inc. of Case Assignment dated 10/18/09.
4. Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 9/28/09.
5. Request Form dated 9/25/09.
6. Request Notes dated 9/18/09.
7. Reconsideration of the Medical Determination dated 9/24/09, 8/28/09.
8. Provider That Received the Denial dated 9/25/09.
9. Follow-Up Visit dated 9/16/09.
10. Patient Information dated 7/1/09.
11. History/Physical Examination dated 7/8/09.
12. Patient Questionnaire dated 7/8/09.
13. Procedure Notes dated 6/26/09, 5/20/09.
14. Left Ankle MRI dated 7/1/09.
15. Examination Report dated 5/26/09.

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:** xx  
**Gender:** Male  
**Date of Injury:** xx/xx/xx  
**Mechanism of Injury:** Caught his leg between a wall and a load of paper  
**Diagnosis:** Lateral ankle pain

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

The claimant is a male who sustained a left ankle injury on xx/xx/xx, when his leg was caught between a load of paper and a wall. An MRI report of the left ankle on 04/07/09 documented mild breaking along the distal dorsal talar margin; otherwise unremarkable. The claimant treated with Dr. initially. He had tenderness of the lateral gutter and sinus tarsi and Dr. provided an injection to this area. On 07/08/09 Dr. evaluated the claimant for left ankle pain. He had some relief with the injection. The claimant had also been treated with physical therapy and was taking Naprosyn and Robaxin. On exam the claimant had a positive left ankle anterior drawer and inversion test. X-rays showed ankle mortise maintained. Dr. felt that the MRI showed changes of the anterior talofibular ligament (ATFL) consistent with the previous injury. The claimant was placed in a lace up brace. The physician recommended left ankle arthroscopy and left ankle modified Broström lateral ligament reconstruction. The surgery was denied on peer review. On 09/16/09 Dr. documented mild swelling about the ankle. There was focal tenderness over the anterolateral ankle. Drawer's testing was grossly positive. The claimant had normal range of motion. Strength testing

revealed subtle weakness to resisted eversion. Tilt and lateral drawer stress x-rays were performed without evidence of lateral opening or excessive increased anterior translation. Surgery was again recommended. Stress radiographs were performed without evidence of lateral opening or excessive increased anterior translation. Based upon this, the guidelines for ODG Guidelines are not satisfactorily met for lateral ligamentous ankle reconstruction. This is a very infrequently performed procedure, and stress radiographs typically are needed to demonstrate a degree of instability, to merit. There was no MRI evidence of talar bone abnormalities that would require any arthroscopic clean-up of the rest of the joint. Based upon these records, surgery is not indicated.

**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.

**X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.**

Official Disability Guidelines (ODG), Treatment Index, 7<sup>th</sup> Edition (Web), 2009, Ankle-Foot, Lateral ligament reconstruction.

*Recommended as indicated below. See also [Surgery for ankle sprains](#).  
ODG Indications for Surgery<sup>TM</sup> -- 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 (performed by a physician) 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, calcaneous osteotomies.*

- 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).