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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 05/17/2011

IRO CASE #:

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

This case was reviewed by an Orthopaedic Surgeon, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ankle stabilization surgery (27698, 29515, 76000, 20926)

REVIEW OUTCOME

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

Overturned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a male employee who sustained an industrial injury to the right foot on xx/xx/xx. He is followed by a podiatrist for continuing right foot complaints. The patient's history includes a right ankle fracture from a work related accident approximately xx years ago.

On xx/xx/xx the patient alleges that his right instep started to hurt so much that he could barely stand on his foot anymore (report cited by first level reviewer).

Right foot MRI performed on January 20, 2011 reportedly showed: Mild tenosynovitis of peroneus longus inferior to the lateral malleolus. Moderate inflammation in subtalar recess/sinus tarsi region. Degenerative subcortical cyst formation involving the

middle cuneiform and the calcaneus, near the insertion of the subtalar ligaments.

Medical report dated January 21, 2011 indicates the patient describes aching and weakness at the right ankle since an injury of several years prior. The sprain is worsening. The affected area is made worse by ambulating and working. He has had a consultation and physical therapy with e-stim, ultrasound, cryo cuff, manual therapy and therapeutic procedures. He is using an ankle brace and cannot work without it. He declines use of medication. His medical history is unremarkable. He has good pulses and normal temperature in the right foot. Sensation is normal. He is able to heel and toe walk. Reflexes are normal. No lesions or color changes are seen. There is pain at the peroneal tendons and at the anterior lateral ankle gutter. There is excessive inversion and positive anterior drawer sign. He has complete instability of the ankle with no signs of improvement since being placed in an ankle gauntlet. X-rays show no fracture or dislocation at the foot or ankle. MRI shows inflammation to the peroneal tendons sinus tarsi and anterior lateral ankle with no ATF ligament noted. Impression is ankle instability, pain difficulty walking and ruptured ATF. He has chronic ankle instability from injury that ruptured the lateral ankle ligament and needs to remain in a brace until his lateral ankle ligaments can be surgically repaired.

The patient returned on March 11, 2011. An ankle brace has helped mildly with the pain. He is unable to walk without the ankle brace. He is 5' 7" and 172 pounds. There is pain at the peroneal tendons and anterior lateral ankle gutter and excessive inversion and anterior drawer sign is positive.

Request for ankle stabilization surgery was considered in review on March 16, 2011 with recommendation for non-certification. Per the reviewer, the patient has undergone appropriate conservative care. The proposed surgery would probably not be effective because there is no ligament to repair laterally. The medical records do not provide evidence to support any specific surgical intervention for chronic ankle instability. The surgical reconstruction for chronic lateral instability was found to be superior to six weeks immobilization (per ODG); however, my experience shows that the ankle should undergo stabilization procedures immediately after the traumatic injury to achieve good results and several years later with a degenerative ATF there is really no good surgical prognosis for the ankle instability, although there may be a tendon overlay procedure or graft material that may be used to replace the original ATF but these procedures are not utilized very often. According to the MRI, no anterior talofibular ligament was noted as being present and the impression from the MRI included degenerative subcortical cyst formation involving the middle cuneiform and involving the calcaneus near the insertion of the subtalar ligaments. An ankle stabilization procedure would not be effective at helping the subcortical cysts which are often very painful and therefore the stabilization would not be medically necessary or appropriate since no ATF has been noted to exist or repair.

The patient was examined by a Designated Doctor (specialty = chiropractic) on March 18, 2011 to determine MMI status and impairment. The patient described constant severe pain at the lateral aspect of the right ankle that is stabbing and numb, worse with ambulating and standing. He related a standing and walking tolerance of 15 minutes. He is a and attributes the injury to twisting and pressing down to maneuver the. He was initially treated with an ankle strap and ibuprofen. He was seen by a chiropractor and diagnosed with sprain/strain of the foot. He had an MRI, x-rays and was referred to a podiatrist. He was a further diagnosed with chronic ankle instability from injury that ruptured the lateral ligaments. Recommendation was for surgery and an ankle brace. The current provider diagnosed a torn right ankle ATF and recommended he remain off work. He has not had any physical therapy to the foot or ankle. He is using Ibuprofen and Remeron for panic and anxiety. On examination of the ankle, he has a limp, favoring the right foot. He is using an ankle brace. Some increased sensation is noted on the right L4-5 dermatomes. Manual muscle testing shows 4/5 strength for the right ankle. There was muscle atrophy of the right lower leg. Ankle temperature is normal. There is no evidence of swelling. There is pain with palpation. Active and passive ROM is limited with pain and guarding. Anterior drawer, talo-fibula stability and ankle dorsiflexion tests produce pain on the lateral aspect of the right ankle. Examination of the foot is unremarkable. He has reached MMI. He has zero WPI (based on ROM). His disability from 12-27-10 to 1-21-11 was the direct result of a work related injury on xx-xx-xx. His right ankle pain complaint is the result of a pre-existing condition. The instability of the right ankle resulted from rupture of the right ATF ligament. He would benefit from surgical repair. If surgery is not scheduled in the near future, he will need physical therapies to prevent further muscle atrophy and weakness of the right lower leg. Diagnosis is sprain/strain of foot.

Request for reconsideration ankle stabilization surgery was considered in review on April 4, 2011 with recommendation for non-certification. Per the reviewer, the documentation elaborates the patient complaining of ongoing right ankle pain. Evidence based guidelines recommend ankle stabilization/reconstruction surgery provided the patient meets specific criteria. No documentation was submitted regarding the patient's physical therapy to include casting/ankle bracing. Additionally, no x-rays were submitted in the documentation. Given the lack of documentation regarding the patient's conservative treatment history as well as x-rays of the affected area, this request does not meet guideline recommendations. As such, the documentation submitted for review does not support this request at this time.

Request was made for an IRO.

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

ODG: 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 (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.

The patient has been seen since December 2010 for right ankle pain and weakness. He underwent x-rays and MRI, although no imaging reports are submitted or have been well-cited. An MRI done in January 2011 was cited as showing, "mild tenosynovitis of peroneus longus inferior to the lateral malleolus. Moderate inflammation in subtalar recess/sinus tarsi region. Degenerative subcortical cyst formation involving the middle cuneiform and the calcaneus, near the insertion of the subtalar ligaments." However, the first level reviewer also reports, according to the MRI, no anterior talofibular ligament was noted as being present. Is the ligament ruptured, retracted and atrophied? Otherwise, the patient meets all the criteria above to proceed with a surgery (PT with bracing, instability, swelling, positive anterior drawer test). Imaging is not sufficiently clarified.

First level review denial rationale notes, according to the MRI, no anterior talofibular ligament was noted as being present and the impression from the MRI included degenerative subcortical cyst formation involving the middle cuneiform and involving the calcaneus near the insertion of the subtalar ligaments. An ankle stabilization procedure would not be effective at helping the subcortical cysts which are often very painful and therefore the stabilization would not be medically necessary or appropriate since no ATF has been noted to exist or repair. This reviewer also noted, he has had a consultation and physical therapy with e-stim, ultrasound, cryo cuff, manual therapy and therapeutic procedures. He is using an ankle brace and cannot work without it.

Second level review denial rationale notes insufficient documentation of conservative treatments and lack of imaging studies.

The DD report has multiple contradictions. It is not clear that "he has not had any physical therapy to the foot or ankle" as per January 21, 2011 report, he has had a consultation and physical therapy with e-stim, ultrasound, cryo cuff, manual therapy and therapeutic procedures. He has a limp, limited standing and walking tolerance, cannot function without a brace, has weakness, atrophy and positive signs of instability. However, he has no impairment and is MMI. He needs a surgery for a ruptured ATF ligament otherwise he will need PT for a diagnosis of sprain/strain. His disability of January-February is from a work related injury, but his right ankle pain complaint is the result of a pre-existing condition (from the fracture of 20 years prior?). This report only adds confusion to the case.

After reviewing all the submitted records, it is clear that the patient needs a surgery. The ankle should and can be stabilized with surgery. Without surgery, the arthritis will progress at a faster rate, the pain will increase, the swelling will increase, and there is less chance that he will return to work.

Therefore, my recommendation is to disagree with the previous non-certification for ankle stabilization surgery (27698, 29515, 76000, 20926).

The IRO's decision is consistent with the following guidelines:

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

__X__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

The Official Disability Guidelines 04-07-2011 Ankle and Foot Chapter: Surgery for ankle sprains

Recommended as indicated below for Grade III1 sprains. Operative treatment for severe ruptures of the lateral ankle ligaments leads to better results than functional treatment, and functional treatment leads to better results than cast immobilization for six weeks. (Pijnenburg, 2000) There was some evidence for a lower incidence of long-term ankle swelling in surgically treated patients. However, as well as tending to take longer to resume normal activities, including work, there was some limited evidence from a few trials for a higher incidence of ankle stiffness, impaired ankle mobility and complications in the surgical treatment group. (Kerhoffs, 2002) In view of the low quality methodology of almost all the studies, this review does not provide sufficient evidence to support any specific surgical intervention for chronic ankle instability. After surgical reconstruction for chronic lateral ankle instability, early functional rehabilitation was shown to be superior to six weeks immobilization regarding time to return to work and sports. (de Vries-Cochrane, 2006) This RCT concluded that, in terms of recovery of the preinjury activity level, the long-term results of surgical treatment of acute lateral ligament rupture of the ankle correspond with those of functional treatment. Although surgery appeared to decrease the prevalence of reinjury of the lateral ligaments, there may be an increased risk for the subsequent development of osteoarthritis. (Pihlajamäki, 2010) According to this systematic review of treatment for ankle sprains, there is a role for surgical intervention in severe acute and chronic ankle injuries, but the evidence is limited. (Seah, 2011) See also Lateral ligament ankle reconstruction.

ODG Indications for Surgeryä -- 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)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

Lateral ligament ankle reconstruction (surgery):

Recommended as indicated below. This RCT concluded that, in terms of recovery of the preinjury activity level, the long-term results of surgical treatment of acute lateral ligament rupture of the ankle correspond with those of functional treatment. Although surgery appeared to decrease the prevalence of reinjury of the lateral ligaments, there may be an increased risk for the subsequent development of osteoarthritis. Surgical treatment comprised suture repair of the injured ligament(s) within the first week after injury, and a below-the-knee plaster cast was worn for six weeks with full weightbearing. Functional treatment consisted of the use of an Aircast ankle brace for three weeks. (Pihlajamäki, 2010) See also Surgery for ankle sprains.

ODG Indications for Surgeryä -- 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
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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, calcaneus osteotomies.
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For average hospital LOS if criteria are met, see Hospital length of stay (LOS).