

**CALIGRA MANAGEMENT, LLC  
1201 ELKFORD LANE  
JUSTIN, TX 76247  
817-726-3015 (phone)  
888-501-0299 (fax)**

Notice of Independent Review Decision

**July 22, 2013**

**IRO CASE #:**

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

MRI right ankle

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

Board Certified Orthopedic Surgeon

**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 the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

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

- Utilization reviews (05/31/13, 06/27/13)
- Office visits (06/04/12 - 05/20/13)
- Procedure (07/11/12)
- Diagnostic (05/01/13)
- Office visits (06/28/12 – 05/20/13)
- Diagnostic (05/24/12, 05/01/13)
- Procedure (07/11/12)
- Therapy (09/06/12)
- Utilization reviews (05/31/13, 06/27/13)

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who on xx/xx/xx, stepped into a gap where there was missing cement. It resulted in an inversion injury to his right ankle. He heard a pop sound loudly.

**2012:** On May 24, 2012, magnetic resonance imaging (MRI) of the right ankle without contrast was performed due to right ankle pain and swelling status post sprain. The findings were small osteochondral lesion at posterolateral talar dome, partial intra-substance longitudinal splitting-type tear within the peroneus brevis tendon, tenosynovitis involving peroneus longus and peroneus brevis tendon and small tibiotalar and posterior subtalar joint effusion.

On June 4, 2012, evaluated the patient for right ankle symptoms. The patient reported hearing a pop sound loudly following the injury. He was seen and evaluated at the Medical Clinic where he was placed in a fracture boot (which was heavily worn away and falling apart). He still had some discomfort, swelling and pain with ambulation and weight bearing. The patient reported a history of ankle sprain but was functioning at work without limitations. Musculoskeletal examination showed mild-to-moderate tenderness along the peroneal tendon from inferior fibular groove to the insertion at the fifth metatarsal and discomfort with forced inversion of the hindfoot. There was mild tenderness to the lateral collateral ankle ligaments without any overt instability. There was mild-to-moderate tenderness to the lateral talar dome and lateral ankle gutter. assessed ankle sprain, partial rupture of the peroneal tendon, osteochondral lesion of the lateral talar dome. He discussed conservative versus surgical intervention and recommended continuing with conservative care. The patient was to continue with fracture boot immobilization and a new boot was dispensed. opined that should symptoms persist, the patient might require surgical intervention.

On June 28, 2012, noted significantly worsening symptoms to the outer ankle area despite using fracture boot for immobilization. The patient had significant pain with ambulation and with weight bearing. He felt that conservative care for several months had simply not provided sustained relief for lateral ankle pain. Examination showed worsening moderate tenderness along the peroneal tendon from inferior fibular groove to the insertion at the fifth metatarsal and discomfort with forced inversion of the hindfoot. There was mild tenderness to the lateral collateral ankle ligaments without any overt instability and negative anterior drawer and talar tilt. There was ongoing moderate tenderness to the lateral talar dome and lateral ankle gutter. assessed ankle sprain, partial rupture of the peroneal tendon and osteochondral lesion of the lateral talar dome. He recommended repair of the peroneal tendon with microfracture and debridement of the lateral talar dome lesion. For the interim, he recommended continuing with fracture boot and limited weight bearing as tolerated.

On July 11, 2012, performed right primary peroneal tendon repair, osteochondral lesion debridement and microfracture with ankle arthrotomy and debridement and application of posterior splint.

On July 19, 2012, noted that the patient was compliant with non-weight bearing with dressing clean, dry and intact. He had minimal pain at that time and only complained of burning/tingling pain in the anterior lateral ankle and along the dorsal lateral foot which had started particularly after hitting his foot against floor and jamming his forefoot earlier that week. Examination showed very slight tenderness along the peroneal course and along the osteochondral lesion of the lateral talar dome. The symptoms were markedly improved. There was full ankle joint range of motion (ROM) without crepitation, impingement or tenderness. assessed ruptured peroneal tendon and osteochondral defect of the talar dome. He felt that the patient was progressing very well and prescribed Gabapentin. The patient was recommended to continue Norco and Phenergan as needed. The patient was instructed to continue non-weight bearing.

On July 26, 2012, that the patient was partially compliant with non-weight bearing with bottom of the splint dirty due to some weight bearing. The patient reported continued improvement and the nerve pain was also improving with Gabapentin. Examination showed very slight tenderness along the peroneal tendon course and along the osteochondral lesion of the lateral talar dome. applied Unna's boot for compression and also a well-padded Jones compression dressing with a posterior splint. The patient was again instructed to continue non-weight bearing and he was to continue Gabapentin, Norco and Phenergan.

On August 2, 2012, noted improving pain and resolving nerve pain with Gabapentin. Examination showed very slight tenderness along the peroneal tendon course and along the osteochondral lesion of the lateral dome. The symptoms were markedly improved. applied Unna's boot, well-padded Jones compression and a posterior splint. He refilled Gabapentin for neuritic symptoms and instructed the patient to continue non-weight bearing.

On August 16, 2012, noted that nerve pain had resolved and the patient had no pain. He recommended beginning showering and applying an Ace wrap for compression. The patient was to transition to fracture boot partial weight bearing as tolerated and was referred to physical therapy (PT).

On August 27, 2012, noted that the patient was progressing very well without any pain or discomfort until a few days prior when during driving, with foot dependent, he noted significant swelling and discomfort to the surgery repair site. Examination showed significant edema along the lateral ankle and effusion along the peroneal tendon repair site which was tender to palpation and to inversion of the hindfoot. applied Unna's boot for compression and recommended continuing fracture boot with limited ambulation and weight bearing. He ordered repeat MRI to rule out any rupture.

On August 31, 2012, noted that the acute episode of pain due to swelling had resolved completely with usage of Unna's boot and fracture boot. The patient was full weight bearing without any pain or discomfort and related 100% resolution of symptoms to the surgery area. Examination showed resolved tenderness along the peroneal tendon course and along the osteochondral region of the lateral talar

dome. felt that the patient could begin ankle brace with athletic type shoe gear and limited ambulation as tolerated. He recommended beginning therapy.

On September 6, 2012, the patient underwent PT evaluation and was recommended eight sessions of therapy consisting of therapeutic exercises, therapeutic activities and manual therapy.

On September 13, 2012, noted that the patient was full weight bearing in ankle brace with regular shoe gear with no pain but some mild swelling and soreness, but he was able to work 60 to 70 hours per week full duty without limitations. Examination showed mild non-pitting edema to the distal fibula along the peroneal tendon groove. There was full ROM (ROM) without crepitation, impingement or tenderness. assessed ruptured peroneal tendon and osteochondral defect talar dome. He noted that the patient was progressing very well. He had not started PT due to approval and the first session was on Monday. recommended continuing PT and ankle brace/regular shoe gear and encouraged the patient to limit weight bearing due to excessive workload.

No records are available from October 2012 through March 2013.

On April 12, 2013, evaluated the patient and noted that for the last seven months the patient had been ambulating and functioning at full capacity without any pain or discomfort. About two weeks ago, he noted pain in the lateral foot without history of trauma or other inciting event. Yesterday he had difficulty weight bearing and ambulating and scheduled a follow-up appointment. He was wearing dress shoes at that time and was ambulating with a slight limp. Examination showed no tenderness along the peroneal tendon course and along the osteochondral region of the lateral talar dome. There was mild non-pitting edema on the distal fibular along the peroneal tendon group. He had full ankle joint ROM without crepitation, impingement or tenderness. New findings of significant discomfort to the lateral subtalar joint and sinus tarsi area especially with direct palpation and forced subtalar joint eversion/inversion ROM. assessed ruptured peroneal tendon, osteochondral defect of the talar bone and sinus tarsi syndrome. He felt that surgery appeared asymptomatic. The patient had no pain along the peroneal tendon course or the osteochondral repair site. The subtalar joint pain was a completely new finding. administered 3 cc steroid mixture of Lidocaine, Marcaine, Kenalog and dexamethasone. The patient noted immediate pain relief. dispensed new ankle brace and recommended limited activities and stiff-soled shoe gear. He also recommended applying ice for 20 minutes twice daily and NSAID therapy as tolerated.

On April 25, 2013, evaluated the patient for sinus tarsi pain. He again related no pain to the peroneal tendon or the osteochondral lesion site. The sinus tarsi pain was much improved for about two weeks but then after playing and walking 18 holes of golf the pain returned. Examination showed very minimal non-pitting edema on the distal fibula along the peroneal tendon groove. There was significant discomfort to the lateral subtalar joint and sinus tarsi area especially with direct palpation and forced subtalar joint eversion/inversion ROM.

recommended continuing ankle brace and limited activities with stiff soled shoe gear. He also recommended continuing ice 20 minutes twice daily and prescribed pain medications. A computerized tomography (CT) was ordered to assess the subtalar joint and sinus tarsi region.

On May 1, 2013, CT of the right ankle showed mildly larger osteochondral lesion of lateral talar dome, small marginal spurs in the anteromedial margin of the talar dome and thickening of the peroneus brevis and peroneus longus tendons.

On May 20, 2013, noted persistent sinus tarsi pain. Examination showed very minimal non-pitting edema to the distal fibula along the peroneal tendon group. There was continued unchanged significant discomfort to the lateral subtalar joint and sinus tarsi area especially with direct palpation and forced subtalar joint eversion/inversion ROM. reviewed the CT scan and recommended continuing ankle brace and limiting activities with stiff soled shoe gear. He prescribed Celebrex and recommended application of ice for 20 minutes twice daily. An MRI was ordered to rule out sinus tarsitis or other ligamentous pathology.

Per utilization review dated May 31, 2013, the request for repeat MRI was of the right ankle was denied, with the following rationale: *“The patient is a male who sustained an injury on xx/xx/xx, secondary to an unspecified mechanism. He is diagnosed with ruptured right peroneal tendon, osteochondral defect of the talar dome and sinus tarsi syndrome. A request is made for MRI of the right ankle. The right ankle MRI dated May 24, 2012, showed small osteochondral lesion at the posterolateral talar dome, partial tear within the peroneus brevis tendon, tenosynovitis and subtalar joint effusion. The patient underwent right primary peroneal repair, osteochondral lesion debridement and microfracture with ankle arthrotomy and debridement on July 11, 2012. He then attended post-operative PT. A right ankle CT was done on May 1, 2013 which showed mildly larger osteochondral lesion of the lateral talar dome, small marginal spurs and thickening of the peroneus tendons. The latest medical report dated May 23, 2013, states that the patient has persistent right sinus tarsi pain. Examination reveals intact neurovascular status. There is very minimal, non-pitting edema in the distal fibula along the peroneal tendon groove. Ankle ROM is normal without crepitation, impingement or tenderness. There is discomfort at the lateral subtalar joint and sinus tarsi area especially with direct palpation and forced subtalar joint eversion/inversion. MRI is requested to rule out sinus tarsitis or other ligamentous pathology. Although the patient has discomfort at the lateral subtalar joint and sinus tarsi area, a more detailed physical examination is not provided. Examination findings suggestive of sinus tarsi syndrome or other ligamentous pathologies are not noted to justify the request for an MRI. The medical necessity of this request cannot be established at this time.”*

Per reconsideration review dated June 27, 2013, repeat MRI of the right ankle was denied, with the following rationale: *“The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The patient's mechanism of injury was not provided in the medical records. The patient's medications are noted to include Celebrex 200 mg once daily. The*

*patient's surgical history is noted to include a right primary peroneal tendon repair, osteochondral lesion debridement, and microfracture with ankle arthrotomy and debridement on July 11, 2012. Diagnostic studies are noted to include an official CT of the ankle without contrast report dated May 1, 2013 suggested a mildly large osteochondral lesion of the lateral talar dome. Small marginal spurs were noted in the anteromedial margin of the talar dome. Thickening of the peroneus brevis and peroneus longus tendons was noted. Other therapies are noted to include physical therapy, ankle brace, ice, and stiff-soled shoe. The request for Repeat Right Ankle MRI without Contrast 73721 is non-certified. This request was previously denied due to a more detailed physical examination was not provided. The patient is a male who reported an injury on xx/xx/xx. Guidelines recommend repeat MRIs be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The documentation submitted for review indicated the patient to have reported difficulty with weight bearing and ambulation after playing and walking 18 holes of golf. The documentation submitted for review indicated the patient's physical exam to suggest the patient to have full ankle ROM without crepitation, impingement, or tenderness. The documentation submitted for review indicated the patient to have significant discomfort to the lateral subtalar joint and sinus tarsi area with direct palpation and forced subtalar joint eversion/inversion range of motion. Based on the documentation submitted for review, physical exam findings of joint instability, weakness or significant changes in symptoms were not identified. As such, the request for Repeat Right Ankle MRI without Contrast 73721 is non-certified.*

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

A repeat MRI right ankle would be considered medically necessary and appropriate based on the records provided in this case and the Official Disability Guidelines. If one looks toward the Official Disability Guidelines, repeat MRI is not routinely recommended and should be reserved for significant change in symptoms and/or findings suggestive of significant pathology. In this case the claimant is status post previous treatment of problems involving peroneal tendon and talar osteochondral lesion. Notes provided document that this claimant did well for following the aforementioned surgery performed back in 07/12. The 04/12/13 note documents that for 7 months the claimant was ambulating in function at full capacity without any pain or discomfort. Some time in early 04/13, this claimant developed lateral foot pain. performed the examination that demonstrated no tenderness along the peroneal tendons or the osteochondral lesion repair site. He felt that the new pain was related to sinus tarsi syndrome and injected the subtalar region with Lidocaine and steroid. This provided short term relief. This claimant was subsequently re-evaluated in April and May 2013. The claimant was treated conservatively with icing, medications, activity modification, bracing and a stiff sole shoe. obtained a CT scan to help assess the subtalar joint in the sinus tarsi region which was unrevealing. This claimant continues to have pain and examination findings which are new and different compared to a year ago when MRI was performed which demonstrated the peroneal tendon and the osteochondral lesion problem. The Official Disability

Guidelines support repeat MRI's if there is a significant change in symptoms or under findings of significant pathology. In this case there is significant change in symptoms. The claimant has been treated appropriately conservatively for several months. At this juncture an MRI of the foot/ankle would be appropriate to evaluate this problem. Therefore per the Official Disability Guidelines, MRI right ankle would be considered medically necessary and appropriate based on the records provided in this case. HJP//tg

---

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**