

Health Decisions, Inc.

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Notice of Independent Review Decision

[Date notice sent to all parties]: June 25, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Ankle Arthroscopic exam, peroneal tendon debridement with possible repair of occult tears, as an Outpatient.

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

This physician is a Board Certified Orthopedic Surgeon with over 40 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

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:

03-15-13: Injury/Illness Record
03-18-13: Right Ankle X-ray, Three Views
03-18-13: Follow-up Record
03-21-13: Follow-up Record
04-02-13: Follow-up Record
04-02-13: Physical Therapy Evaluation
04-05-13: Physical Therapy Note
04-09-13: Follow-up Record
04-23-13: Orthopedic Evaluation
05-13-13: MRI of the Right Ankle without Contrast
05-14-13: Orthopedic Follow-up
05-24-13: UR performed
06-04-13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

the claimant, a female, was evaluated at for an ankle injury that occurred on xx/xx/xx. She was walking to the building, stepped off uneven pavement inverting her ankle and heard a "pop" in her right ankle. On physical examination she had minimal edema over the right lateral malleolus and increased tenderness to palpation of posterior malleolus. Diagnosis: Right ankle sprain. Plan: x-ray right ankle, OTC ibuprofen, elevate & ice, ankle brace.

Right Ankle X-ray, Three Views, Impression: Mild lateral ankle soft tissue swelling without evidence of acute underlying fracture.

March 18, 2013, the claimant was re-evaluated (doctor not clearly identified) for continued pain rate 5-6/10 to the medial malleolus on palpation and to the lateral malleolus when she performs pronation. On exam she was noted to be limping, edema 2+ to medial malleolus and 1+ to lateral malleolus. Limited supination, pronation, dorsiflexion and plantar flexion. No ligament laxity. She was instructed to ice right ankle 20 minutes every 1-2 hours, wear elastic support, and take Ibuprofen 400 mg.

April 2, 2013, the claimant had a physical therapy evaluation by PT where therapy was recommended 3 days a week for 2 weeks.

April 9, 2013, the claimant was re-evaluated and noted to be going to work with a walking boot on.

April 23, 2013, the claimant had an orthopedic evaluation who noted she had been in multiple braces and had physical therapy. He also noted the claimant apparently quit her job. She continued to complain of pain and swelling mostly along the lateral aspect of her ankle. She complained of some ankle instability. On exam she ambulated with an antalgic gait with an ankle support. There was swelling along the lateral aspect of the ankle. There was tenderness at the peroneal tendons which appeared to be stable to foot circumduction. There was also some tenderness at the anterior talofibular ligament. The Achilles tendon was intact. There was some tenderness at the posterior tibialis tendon at the level of medial malleolus. She tolerated almost full ankle range of motion. There was laxity to anterior drawer testing. There was some negative squeeze test and negative external rotation test. Impression: 1. Right ankle sprain. 2. Right peroneal tenosynovitis versus tearing. 3. Right posterior tibialis tenosynovitis. Plan: Continue with home therapy, Ibuprofen, and ankle support. Get MRI of the ankle for further evaluation.

MRI of the Right Ankle, Impression: 1. A small area of altered signal intensity in the lateral aspect of the dome of the talus, as described above. It probably represents an area of osteochondritis dissecans. 2. Tendoachilles tendonitis. 4. Minimal synovial effusion in ankle, intertarsal, and tarsometatarsal joints. 4. Mild subcutaneous edema around the ankle joint.

May 14, 2013, the claimant was re-evaluated who noted on physical examination she ambulated with an antalgic gait, there was some tenderness at the lateral

aspect of the ankle as well as in the retrofibular groove region and there was no specific area of medial ankle tenderness. There was good ankle range of motion with mild laxity to anterior drawer testing. Plan: stated the claimant was clearly not responding to nonoperative management and recommended a right ankle arthroscopic examination with treatment of intraarticular pathology as needed as well as peroneal tendon debridement with possible repair of occult tears which are often missed on an MRI.

May 24, 2012, performed a UR. Rationale for Denial: The request is not medically supported. I spoke to Viviana, and she stated that the MRI showed some Achilles tendonitis and an irregular signal on the talus. She stated there was an ankle joint injection no relief. Based on MRI evaluation, there was no clear pathology of the peroneal tendon. The orthopedic surgeon indicates that peroneal tendon occult tears are often missed on MRI. The orthopedist also indicated that the claimant was non-responsive to non-operative management. However, without significant inflammation about the ankle joint or clear evidence of pathology by MRI with a recent injury and without formal physical therapy, the request is not medically supported. Peer review guidelines indicate that for surgery for peroneal tendonitis and tendon rupture, the treatment guidelines recommend conservative treatment for tendonitis and surgery as an option for a ruptured tendon. Individuals with peroneal tendonitis, but no significant peroneal tendon tear, can usually be treated successfully nonoperatively. The request for right ankle arthroscopic examination, peroneal tendon debridement with possible repair of occult tears, as an outpatient, is not-certified.

June 4, 2013, performed a UR. Rationale for Denial: The request for ankle arthroscopy in this particular case would be considered reasonable and appropriate to the extent the claimant has MRI scan evidence of a lateral talar dome lesion consistent with that of osteochondritis dissecans. She has failed conservative care which has included physical therapy, ibuprofen, and multiple braces. She has an antalgic gait and lateral complaints that would be consistent with the MRI scan findings. Arthroscopic surgery in this setting would be considered reasonable, appropriate, and consistent with the evidence-based Official Disability Guidelines. The records do not provide any indications of peroneal tendon pathology. In particular, the MRI scan does not identify evidence of peroneal tendinitis. The objective findings of lateral ankle pain would appear to be most consistent with that of the osteochondral lesion in the lateral talar dome. Without more objective evidence of peroneal tendon pathology either on exam and/or imaging studies, it would be unclear as to the indications for peroneal tendon debridement. One would not routinely explore the peroneal tendons in the face of a symptomatic osteochondral lesion. Thus, without more objective evidence of indications for this area, the request for that portion of the procedure would not be considered reasonable or medically necessary. Since a peer to peer was not successful, the entire request is recommended for non-certification.

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

The previous adverse determinations are upheld. There was no specific indication of peroneal tendon tear or rupture. There was no specific documentation of loose body, osteochondritis desiccant, torn ligaments, or instability. Therefore, no indication for arthroscope of ankle, or peroneal tendon surgery. Only 2 physical therapy visit notes were provided for review and no documentation of the success or lack thereof during physical therapy was provided. Without adequate documentation of failed conservative treatment, the request does not meet ODG guidelines and the request for Right Ankle Arthroscopic exam, peroneal tendon debridement with possible repair of occult tears, as an Outpatient is found to not be medically necessary at this time.

PER ODG:

Arthroscopy	<p>Recommended. An arthroscope is a tool like a camera that allows the physician to see the inside of a joint, and the surgeon is sometimes able to perform surgery through an arthroscope, which makes recovery faster and easier. Having started as a mainly diagnostic tool, ankle arthroscopy has become a reliable procedure for the treatment of various ankle problems. (Stufkens, 2009) Ankle arthroscopy provides the surgeon with a minimally invasive treatment option for a wide variety of indications, such as impingement, osteochondral defects, loose bodies, ossicles, synovitis, adhesions, and instability. Posterior ankle pathology can be treated using endoscopic hindfoot portals. It compares favorably to open surgery with regard to less morbidity and a quicker recovery. (de Leeuw, 2009) There exists fair evidence-based literature to support a recommendation for the use of ankle arthroscopy for the treatment of ankle impingement and osteochondral lesions and for ankle arthrodesis. Ankle arthroscopy for ankle instability, septic arthritis, arthrofibrosis, and removal of loose bodies is supported with only poor-quality evidence. Except for arthrodesis, treatment of ankle arthritis, excluding isolated bony impingement, is not effective and therefore this indication is not recommended. Finally, there is insufficient evidence-based literature to support or refute the benefit of arthroscopy for the treatment of synovitis and fractures. (Glazebrook, 2009) See also Diagnostic arthroscopy, or the Surgery listings for detailed information on specific treatments that may be done arthroscopically.</p>
Diagnostic arthroscopy	<p>Recommended as indicated below. Having started as a mainly diagnostic tool, there has been a gradual shift towards other, less invasive modalities to diagnose ankle pathology, leaving the arthroscope to be a mainly therapeutic tool. However, there are still some indications in which the diagnostic aspect of arthroscopy can be of value. These include articular assessment after ankle fracture and after ankle sprain. Absolute contraindications for ankle arthroscopy are infection and severe degenerative joint disease. Relative contraindications are joint space narrowing or moderate to severe arthrosis, vascular disease and oedema. In the past diagnostic arthroscopy was performed in cases of unexplained pain, swelling, stiffness, haemarthrosis, locking and ankle instability. The role of diagnostic ankle arthroscopy is currently limited due to the increased accuracy of radiological procedures and due to the fact that diagnostic ankle arthroscopy has been demonstrated to be associated with relatively poor outcome. (Stufkens, 2009) Second-look arthroscopy is not necessary to evaluate repaired talar cartilage compared to MRI. (Lee2, 2010) MRI has very high specificity and positive predictive value in diagnosing tears of the anterior talofibular ligament, calcaneofibular ligament and osteochondral lesions. However sensitivity was low with MRI. In a symptomatic patient with ligamentous and chondral pathology in the ankle, negative results on MRI must be viewed with caution and an arthroscopy may</p>

	still be required for a definitive diagnosis and treatment. (Joshy, 2010)
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Peroneal tendinitis/ tendon rupture (treatment)	Recommend conservative treatment for tendinitis, and surgery as an option for a ruptured tendon. Patients with peroneal tendonitis, but no significant peroneal tendon tear, can usually be treated successfully non-operatively. In patients with a large peroneal tendon tear or a bony prominence that is serving as a physical irritant to the tendon, surgery may be beneficial. Peroneal tendonitis is an irritation to the tendons that run past the back outside part of the ankle, and it is a common cause of lateral ankle pain. Commonly it is an overuse condition that responds to conservative treatment, but if it is left untreated it can progress to a complete tendon rupture. Predisposing factors for peroneal tendonitis and rupture include varus alignment of the hindfoot and peroneal subluxation and dislocation. Participation in certain sports, including downhill skiing, skating, ballet, running and soccer creates higher risk for peroneal tendon tears. If caught early, peroneal tendonitis or instability may be treated conservatively with NSAIDs, immobilization and avoidance of exacerbating activities. Once secondary changes in the tendon occur, however, surgical treatment often becomes necessary. Surgery is indicated in the acute phase for peroneus brevis tendon rupture, acute dislocation, anomalous peroneal brevis muscle hypertrophy, and in peroneus longus tears that are associated with diminished function. (Cerrato, 2009)
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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)**