

Medical Assessments, Inc.

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Notice of Independent Review Decision

June 24, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopy, ankle; extensive debridement

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

The Reviewer is a Board Certified Orthopaedic Surgeon with over 42 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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who slipped while on the job and sustained an inversion-type injury to her right foot and ankle on xx/xx/xx.

Xx/xx/xx: Right Ankle X-Ray. **Impression:** 1. Mild lateral ankle soft tissue swelling without evidence of acute underlying fracture.

Xx/xx/xx: Right Foot X-Ray. **Impression:** 1. Questionable hairline fracture along the base of the fifth metatarsal of the right foot versus artifacts. Recommend clinical correlation.

2/04/2014: Examination. **Physical Exam:** Musculoskeletal: The right ankle has diffuse swelling. There is tenderness mostly at the anterior talofibular ligament region. The Achilles tendon is intact. The peroneal tendons are stable. She tolerates general ankle range of motion. There is no gross laxity to anterior drawer talar tilt testing. There is also some tenderness at the 5th metatarsal base region. Skin is intact. Light touch is intact. There are good distal pulses. There is normal alignment.

3/04/2014: Orthopedic Follow up. **Physical Examination:** Claimant ambulates on her right lower extremity with an antalgic gait in her ankle support. There is no significant tenderness at the 5th metatarsal base or lateral aspect of the ankle. There is tenderness at the medial malleolus as well as around the flexor tendons at the level of the ankle joint. Light touch is intact with good distal pulses. There are no gross deformities noted. **Plan:** Advised of the finding at length with the claimant. Due to her persistent pain, recommended an MRI of the ankle for further evaluation. She will continue with home exercise program and ankle support. She will continue with light duty work. Will see claimant back after MRI and go over result and discuss further treatment plan.

3/18/2014: MRI of the Right Ankle without Contrast. **Impression:** 1. Chronic partial tear within an attenuated yet intact right anterior talofibular ligament. 2. Large plantar calcaneal spur without evidence for plantar fasciitis. 3. Moderate to large insertional enthesophyte at the Achilles calcaneal insertion without significant randinopathy, partial or any full or thickness tear. 4. Longitudinal split of the peroneus brevis originating at the posterior fibular groove and extending for 1 cm about the lateral malleolus, has a normal insertion on the base of the fifth as expected. No full thickness rupture. 5. No focal abnormality in the area of concern with overlying skin marker in the posteromedial aspect of the ankle.

3/25/2014: Orthopedic Follow up. MRI of the right ankle from March 18, 2014 shows a tear in the anterior talofibular ligament. There also appears to be a longitudinal split tear in the peroneus brevis. **Plan:** Went over the findings at length with claimant. Discussed possible surgical treatment for the tendon tear and ankle pain with the repair and ankle arthroscopy. Recommended she continue her home therapy program. She will take anti-inflammatory medication or Tylenol as needed for pain. She will continue with work restrictions.

5/07/2014: UR. Rational for Denial: There is no obvious intraarticular pathology documented on the right ankle MRI. There are no significant objective abnormalities found on physical exam to support the necessity of an Arthroscopy or surgical procedure at this time. The guidelines state peroneal tendon repair is indicated for full-thickness rupture was noted. The guidelines indicate diagnostic arthroscopy of the ankle can be useful for assessment of articular assessment after ankle fracture and after ankle sprain. The provided records do not indicate that the claimant sustained any fracture of the ankle, and no instability of the ankle was noted, indicating a possibility of intra-articular pathology after ankle sprain.

Based on these factors, the request for right ankle arthroscopy with peroneus brevis tendon repair is not certified.

6/06/2014: UR. Rational for Denial: This is a non-certification of a reconsideration request for right ankle-arthroscopy with peroneus brevis tendon repair. The previous non-certification on May 6, 2014, stated that there were no significant objective abnormalities found on physical examination to support the necessity of arthroscopy or surgical procedure. It was noted that the guidelines state peroneal tendon repair is indicated for full-thickness ruptures or tears associated with diminished function, but no documentation of diminished function of the peroneus brevis tendon or a full-thickness rupture. There are no additional medical records provided for review for the reconsideration process. The previous non-certification is supported. On physical examination, the ankle was reported to be stable. The MRI reported no full-thickness tear, as required by the guidelines for surgical procedure. Based on the medical records available for review and the peer-reviewed, evidence-based Official Disability Guidelines, the reconsideration request for right ankle arthroscopy with peroneus brevis tendon repair is non certified.

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

The previous adverse determinations are upheld. There are no intra-articular abnormalities noted on X-Ray or MRI and no records indicating ankle instability. Based on her available records arthroscopy of her ankle is not indicated. Therefore, the request for Arthroscopy, ankle; extensive debridement is non-certified at this time.

ODG Guidelines:

urgery for posterior tibial tendon ruptures	Recommended as indicated below. In the early stages, posterior tibial tendon dysfunction may be treated with rest, nonsteroidal anti-inflammatory drugs such as aspirin or ibuprofen, and immobilization of the foot for 6 to 8 weeks with a rigid below-knee cast or boot to prevent overuse. After the cast is removed, shoe inserts such as a heel wedge or arch support may be helpful. If the condition is advanced, a custom-made ankle-foot orthosis or support may be necessary. If conservative treatments don't work, surgery is necessary. The function of the posterior tibial (PT) tendon is to stabilize the hindfoot against valgus and eversion forces. It functions as the primary inverter of the foot and assists the Achilles tendon in plantar flexion. Acute injuries of the PT tendon are rare and mostly affect the active middle-aged patient or they are the result of complex injuries to the ankle joint complex. Dysfunction of the PT tendon following degeneration and rupture, in contrast, has shown an increasing incidence in recent years, and advancing age, comorbidities, and obesity may play a role. Dysfunction of the PT tendon results in progressive destabilization of the hind- and midfoot. Clinically, the ongoing deformation of the foot can be classified into four stages: in stage I, the deformity is distinct and fully correctable; in stage II, the deformity is obvious, but still correctable; in stage III, the deformity has become stiff; and in stage IV, the ankle joint is also involved in the deformity. Treatment modalities depend on stage: while conservative measures may work in early stages, surgical treatment is mandatory for the later stages. Reconstructive surgery is advised in stage II, whereas in stage III and IV correcting
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and stabilizing arthrodeses are advised. See also [Fusion](#) (arthrodesis). A promising treatment option for stage IV may be adding an ankle prosthesis to a triple arthrodesis, as long as the remaining competence of the deltoid ligament is sufficient. ([Hintermann, 2010](#)) Adult flatfoot deformity can arise from multiple causes, the most common of which remains posterior tibial tendon rupture with subsequent elongation of secondary supportive structures. Regardless of the cause, the fundamental goals of surgical management include correcting peritalar subluxation, restoring hindfoot-midfoot-forefoot relationships and muscle balance, attaining a plantigrade foot, and preserving motion when possible. ([Lin, 2011](#)) See also [Adult acquired flatfoot](#) (pes planus).

Arthroscopy

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.

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)**