

**Health Decisions, Inc.**  
**4517 Coconino Court**  
**Fort Worth, TX 76137**  
**P 972-800-0641**  
**F 888-349-9735**

Notice of Independent Review Decision

May 5, 2014

**IRO CASE #:**

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

1 Right ankle arthroscopy, ORIF right distal fibula with calcaneal autograft, possible syndesmosis ORIF, as outpatient

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

An American 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:

Partially Overturned (Agree in part/Disagree in part)

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]:**

A female who sustained an injury to her right ankle on xx/xx/xx, for which the mechanism of injury is not provided. She completed PT although amount is not disclosed. The only pain medications she has taken are Tylenol and Aleve which did not provide relief.

02-07-14: MRI Lower Extremity Joint without Contrast. Impression: 1. Oblique fracture of the distal fibula with superimposed hiatal sprain as described.

03-25-14: Office Visit Report. The claimant presents with pain at the distal fibula and ankle region. She has finished her PT and is frustrated with her lack of progress. She has been taking Tylenol or Aleve for pain. Upon examination, she ambulates on her right lower extremity with an antalgic gait. The claimant has significant tenderness at the distal fibula fracture site and some around the lateral ankle gutter and sinus tarsi region. There is decreased ROM d/t pain. There is a positive squeeze test and a positive external rotation test. On 03-19-14 a 3 view x-ray of the claimant's right ankle were taken. The distal fibula fracture line is still clearly evident. The ankle mortise is intact. Impression and Recommendations: 1. Right ankle sprain. 2. Right distal fibula fracture. Recommend a right distal fibula ORIF with bone graft, ankle arthroscopy with debridement, and possible syndesmosis ORIF.

04-02-14: URA. Rationale: The claimant is a female who sustained an injury to her right ankle on xx/xx/xx. The claimant did undergo an MRI of the ankle on 2-7-14 which showed absorption along the fracture margin of the distal fibula fracture consistent with a subacute healing injury, with irregularity and buckling of the anterior tib-fib ligament. The claimant was then seen on 3-25-14 at which time the claimant was complaining of right ankle pain. The claimant has been taking Tylenol and Aleve for pain. The claimant does smoke. On physical examination she was tender over the distal fibula, with tenderness in the lateral ankle gutter and sinus tarsi, decreased range of motion of the ankle, positive squeeze test, and positive external rotation test. X-ray showed the fracture clearly evident. Surgery was recommended. The request is for right distal fibula ORIF with bone graft ankle arthroscopy, debridement and possible syndesmosis ORIF, as an outpatient, without peer-to-peer partial certification for surgery cannot be made. The right ankle arthroscopy is not medically necessary as the MRI that was performed showed no intra-articular pathology. Therefore the request as submitted is recommended for non-certification.

04-11-14: URA. Rationale: This is a female who was injured on xx/xx/xx. The mechanism of injury is not provided. The claimant has been diagnosed with a distal fibula fracture involving the right lower extremity. An MRI study was accomplished on February 7, 2014. The MRI study documented an oblique fracture through the distal fibula with some resorption along the fracture margins consistent with subacute/healing injury. The ankle mortise was noted to be congruent. The talar dome was noted to be smooth. The sinus tarsi and contents were noted to be unremarkable. Some buckling of the anterior tib-fib ligament was noted. The claimant was most recently evaluated on March 25, 2014. The physical examination findings documented tenderness to palpation over the distal fibula over the fracture site. Some tenderness to palpation over the lateral gutter was also noted. Range of motion was noted to be decreased with a positive squeeze test. There was no documentation of any instability with anterior or posterior drawer testing of the ankle. This is a reconsideration request for a previously non-certified request for an open reduction and internal fixation of a distal fibula fracture with bone graft, arthroscopy with debridement, and possible syndesmosis ORIF. The previous non-certification was based on the fact that it was not felt a right ankle arthroscopy was indicated due to lack of any intra-

articular pathology. Since a peer to peer could not be accomplished, a partial certification of the surgery cannot be provided. No additional information has been provided. The claimant is noted to have an oblique fracture through the distal fibula. An evaluation on March 25, 2014 documented that the fracture line was still evident. The claimant was noted to have tenderness to palpation over the fracture site and a positive squeeze test. Treatment guidelines would support open reduction and internal fixation of a fracture provided the fracture has gone on to nonunion and is displaced. The claimant appears to have delayed union of the fracture, but no evidence of any displacement of the fracture is documented. No intra-articular pathology was noted on the MRI study to support the medical necessity of an ankle scope and no ligamentous instability was documented on the physical examination findings. The syndesmosis was not noted to be displaced. The ankle mortise was noted to be intact. This does not support the possible open reduction internal fixation of the syndesmosis. Since all the procedures requested cannot be deemed medically indicated, the request is non-certified at this time.

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

The previous adverse determinations are partially overturned. Based on review of the records provided, it appears that she has a nonunion of a fibulae fracture that will require a fibular ORIF and bone graft. Her records do not indicate the need for an arthroscopy or syndesmosis screw/ORIF, as there is no indication of widening of the tibia-fibula syndesmosis. Therefore, the request for 1 Right ankle arthroscopy and possible syndesmosis ORIF, as outpatient, is denied, but the request for ORIF right distal fibula with calcaneal autograft is found to be medically necessary.

Per ODG:

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. ( <a href="#">Glazebrook, 2009</a> ) See also <a href="#">Diagnostic arthroscopy</a> , or the <a href="#">Surgery</a> listings for detailed information on specific treatments that may be done arthroscopically.
Diagnostic arthroscopy	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. ( <a href="#">Stufkens, 2009</a> ) Second-look arthroscopy is not necessary to evaluate repaired talar cartilage compared to MRI. ( <a href="#">Lee2, 2010</a> ) 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 still be required for a definitive diagnosis and treatment. ( <a href="#">Joshy, 2010</a> )
Open reduction internal fixation (ORIF)	Recommended as an option for fractures when radiographic evidence indicates a displaced fracture or comminuted fracture, or an open fracture with bone protrusion. Open reduction internal fixation (ORIF) is a method of surgically repairing a fractured bone, in which surgery is used to reduce or set the fracture fragments and then hardware (such as a rod, plate and/or nails) is then implanted to hold the reduction in place. ( <a href="#">Lange, 2007</a> )

**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)**