

MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: June 15, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left ankle Brostrom ligament reconstruction.

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

M.D., Board Certified in Orthopedic Surgery.

REVIEW OUTCOME

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

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

I have determined that the requested left ankle Brostrom ligament reconstruction is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx while trying to climb stairs. Magnetic resonance imaging (MRI) dated 1/13/15 revealed a focal bone contusion involving the mid and distal lateral calcaneus without fracture. There was mild sinus tarsi inflammation, as well as thickening of the medial bundle plantar fascia. An electromyography (EMG) report dated 4/30/15 revealed a normal study. Prior therapies included physical therapy, icing and anti-inflammatory medications. Physical examination on 5/13/15 noted normal inspection/palpation of the left lower extremity, with normal range of motion, muscle strength and tone, and stability.

The patient's medication included ibuprofen, oxycodone, and Tylenol #3. A request has been submitted for a left ankle Brostrom ligament reconstruction.

The URA indicated that the requested services are not medically necessary per Official Disability Guidelines (ODG). Specifically, the initial denial noted that there was no documentation that the patient has received any positive stress x-rays identifying motion at the ankle or subtalar joint and there was no documentation of at least 15 degrees lateral opening at the ankle joint or any demonstrable subtalar movement. On appeal, the URA noted that there was no positive stress x-ray submitted for review, and the patient did not meet criteria regarding subjective and objective findings.

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

The ODG indicate that a surgery for ankle sprain is appropriate if there is documentation of a failure of physical therapy including immobilization with support cast or ankle brace and rehabilitation program, instability of the ankle on examination, complaint of swelling, a positive anterior drawer test, and positive stress x-rays identifying motion at the ankle or subtalar joint of at least 15 degrees in the lateral opening at the ankle or demonstrable subtalar movement and there should be negative to minimal arthritic joint changes on x-ray. The patient was noted to have an x-ray of the left ankle which was negative for a fracture. The patient had been treated conservatively with physical therapy and an air boot. The patient has a positive anterior drawer test on physical examination. However, there was a lack of documentation of subjective findings of instability in the ankle and a lack of documentation of positive stress x-rays identifying motion at the ankle or subtalar joint and at least 15 degrees lateral opening of the ankle joint or demonstrable subtalar movement. As such, the requested left ankle Brostrom ligament reconstruction is not medically necessary for the treatment of this patient.

Therefore, I have determined the requested left ankle Brostrom ligament reconstruction is not medically necessary for treatment of the patient's medical condition.

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 JUDGMENT, 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)