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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Surgical reconstruction of left ankle lateral ligaments, postoperative immobilization with protected weightbearing in pneumatic boot

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

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on XX/XX/XX, while employed. He reported a tree fell on him causing injury to the left lower extremity/ankle.

On XX/XX/XX, the patient was seen at XX. He complained of swelling, pain and bruising on the lateral side of the foot, heel, left lateral malleolus and dorsum of the left foot. The patient reported having a hard time weightbearing. He was given a tetanus injection, Motrin and Norco. Left lower extremity examination revealed ecchymosis on the left distal leg, left lateral malleolus and lateral aspect of the foot/heel. There was swelling at the toes and pain to palpitation. Range of motion (ROM) of the thoracic area was painful and vertebral tenderness was noted at T6-T0. He was diagnosed with fracture of left knee and foot. X-rays of the left ankle, foot, thoracic and lumbar spine were ordered.

From XX/XX/XX to XX/XX/XX, the patient underwent three sessions of physical therapy (PT). Modalities were myofascial release and joint mobilization.

On XX/XX/XX, a magnetic resonance imaging (MRI) of the left ankle showed a healing fracture of the distal fibula in near anatomic alignment. Additional imaging was suggested as clinically indicated. There was deficiency of the fibulocalcaneal ligament of uncertain chronicity noted.

Per Work Compensation report on XX/XX/XX, by an unknown provider, the patient had left foot pain, left fibula pain, tingling/numbness of the first and second toes of the left foot, neck pain, tingling in both hands, left upper to lower thoracic pain, low back pain and left shoulder pain. Orthopedic evaluation showed positive shoulder depressor, Soto Hall, foraminal compression, Bechterew's, straight leg raise (SLR), Yeoman's and empty can test. The patient had a decreased sensation to the L5 dermatome on the left lower extremity. ROM was decreased with mild pain.

On XX/XX/XX, XX saw the patient for evaluation of left foot pain and swelling. The patient reported throbbing left foot/ankle pain rated as 6-7/10. It was noted the patient had been treated with immobilization, activity and shoe modification, NSAIDs and therapy for left foot. Examination of the left ankle/foot revealed mild swelling, abnormal soft tissue change, dorsal midfoot and hindfoot tenderness and lateral aspect ankle tenderness. The patient had a positive anterior drawer test. X-rays of the left ankle revealed healed lateral malleolus fracture. X-ray of the left foot showed well-healed third and fourth metatarsal fracture. He was diagnosed with closed fracture of the lateral malleolus, closed fracture of the metatarsal and sprain of the ankle. Fractures were healed and the patient was recommended for shoe modification. Mobic was prescribed.

On XX/XX/XX, the patient followed up. He reported pain and swelling in the left lower extremity. The patient underwent PT. He had mild foot swelling, dorsal mid foot and hindfoot tenderness. The patient showed a positive anterior drawer test of the ankle. He was prescribed Norco and was instructed to complete therapy and to use the transcutaneous electrical nerve stimulation (TENS) unit.

On XX/XX/XX, the patient was seen for follow up of injury to his left foot/ankle. He was advised to continue work restrictions and to use compound cream to the left ankle.

On XX/XX/XX, a physician advisor report was completed. the request for surgical reconstruction of the left ankle ligament was non-authorized. Rationale: "The records indicate this patient has a positive anterior drawer test and a positive talar tilt test. An MR was reviewed, but not submitted revealing a fibulocalcaneal ligament deficiency The guidelines state there should be positive stress x-rays (performed by a physician) identifying motion at the ankle or subtalar joint. At least 15 degrees lateral opening at the ankle joint OR demonstrable subtalar movement and negative to minimal arthritic joint changes on x-ray. Stress x-rays were not provided tor this review, and the MRI report was not provided for this review, to objectively document pathology to the left ankle. One progress note was submitted, and thus, the scope and breadth of conservative care cannot be objectively documented. The recommendation is for non-certification."

On XX/XX/XX, XX performed a peer review and rendered the following opinions: The patient has been found at MMI as of XX/XX/XX, with 0% whole person impairment per a designated doctor exam. Prior to that, the patient was found to be at MMI as of XX/XX/XX, with 0% impairment by a doctor that his treating doctor had referred the patient to. Based on both of these assessments, the ODG would not support any additional active treatment as related to the left ankle lateral malleolus fracture that has healed, and the left third and fourth metatarsal fractures that have healed per x-ray reports. The patient appeared to have recently changed treating doctors to a chiropractor who has referred the patient to an orthopedic surgeon. The ODG would not support any chiropractic treatment at this time. Based on the recent x-ray and exam findings in the left ankle and the left 3rd and 4th toes, there is no additional active formal PT, DME products, work hardening/conditioning, pain management, injections, prescription medications or surgery reasonable per ODG criteria as related to the XX/XX/XX, work event. The ODG would support return to productive employment, home exercise, an over the counter analgesic and the occasional use of an over the counter nonsteroidal if effective. Only in the event of an acute flare up in left ankle, or left 3rd and 4th metatarsal symptoms would follow up with a treating orthopedic surgeon be reasonable. Otherwise, there is no medical necessity for ongoing active treatment as related to the work event. The complaints recently reported of neck pain, thoracic pain, low back pain, and left shoulder pain were not produced, accelerated or aggravated by the XX/XX/XX, work event. The current ongoing subjective complaints in the left ankle and the left 3rd and 4th metatarsals cannot be objectively explained by orthopedic exam findings or diagnostic findings.

On XX/XX/XX, a work compensation report was completed. The patient was diagnosed with fractured third and fourth metatarsal of the left foot, fracture of distal left fibula, and sprain/strain of calcaneofibular ligament, left ankle-tear.

On XX/XX/XX, a physician advisor was completed. The appeal for surgical reconstruction of the left ankle ligament was non-authorized. Rationale: “Regarding surgical reconstruction of left ankle ligament, ODG indications for lateral ankle ligament reconstruction include subjective instability of the ankle, swelling, and a correlating inversion/hyperextension Injury; conservative care, physical therapy (Immobilization with support cast or ankle brace and Rehab program), objective findings including an anterior drawer and/or medial incompetence, as well as imaging findings. A XX/XX/XX, letter of adverse determination was provided for review. There remains no documentation of stress films identifying at least 15" lateral opening of the ankle joint, demonstrable subtalar movement and minimal arthritic joint changes. The most recent note described x-rays showing healed fractures. Peer to peer was attempted and not established. The request was still not substan6ated. Recommend non-certification.”

On XX/XX/XX, a work compensation report was completed. He stated the patient was not currently medically stationary.

On XX/XX/XX, a functional capacity evaluation (FCE) indicated the patient was at a light physical demand level (PDL). He was able to sit constantly, stand and walk for 30 minutes, bend, climb,

stoop, kneel, crawl occasionally, and reach frequently. He was able to lift 20 pounds. His Fear Avoidance Behavior Questionnaire score was 42. The patient's work demanded heavy PDL. FCE results indicated the patient was not capable of working at pre-injury occupation as a Landscaper as he had significant postural, repetitive movement and material handling restrictions and limitations that must be observed to minimize the risk of aggravation and further injury. As such if the patient were to be placed to work, then he should be placed on modified work duty, Light PDL, until such time that the patient was able to perform at the Heavy PDL of his occupation as a Landscaper.
On XX/XX/XX, XX completed a Report of Medical Evaluation. He stated the patient had not reached MMI and was expected to reach on XX/XX/XX. The whole person impaired for the ankle was 3% and hindfoot was 1% combining to given 4% whole person impairment (WPI). The extent of injury included ankle/foot fracture, Grade II Left ankle/foot strain and sprain; nondisplaced fracture of the lateral malleolus of the left fibula, sequela; left foot closed fracture of the 3rd and 4th metatarsals. The compensable injury also extended to and included: left foot/metatarsal pain, disuse osteopenia as well as cervical and thoracic strain/sprain and left shoulder, left wrist and left hip strain/sprain for the impact and the weight of the tree when it fell on him as well as lumbar strain/sprain from prolonged limping that altered the gait and stresses the lumbar spine.

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

The request for the surgical reconstructions lateral ligaments of the left ankle does not appear to be warranted in this case. There is a very extensive history in regards to this claimant's care dating back to the injury of XX/XX/XX. The claimant has been under the care of multiple providers as noted above. There appears to have been an MRI that was obtained of the ankle early on in the process of this claimant's care which showed a healed fibula fracture as well as attenuation of the calcaneal fibular ligament with questionable duration of symptomatology. There is also evidence in the medical records of a healed third and fourth metatarsal fracture as well. There has been medication documentation that the claimant does have a "positive anterior drawer and talar testing, but there is no evidence of any true stress x-rays obtained demonstrating objective findings of instability of the ankle. It is also unclear whether the claimant has completed a true full course of physical therapy with proprioceptive guidelines and rehabilitation. Please note that it is somewhat unclear in this reviewer's opinion as to the actual mechanism of injury. It appears that this was more of a crush injury where there is fracture of the distal fibular which would not necessarily lead to a condition of instability. This would clearly be dependent upon the position of the claimant's foot and ankle at the time of injury. The majority of the claimant's with trauma to the ATFL/CFL region will heal with conservative measures including aggressive rehabilitation/proprioceptive exercises as well as immobilization with an ankle brace. Again, based on lack of documentation of true stress x-rays, as well as lack of documentation of completion of a true proprioceptive course of physical therapy, the request for further surgical intervention would be inappropriate at this time. Please note it is also reviewed in the medical records that the claimant has had a Functional Capacity Evaluation, as well as medical evaluation. In that report, there appears to be documentation of MMI with zero (0%) percent impairment by the physician at that point.

Based on the documentation provided above as well as current guidelines and standard of care, the request for a lateral ligament reconstruction would be inadvisable at this point

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

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

Official Disability Guidelines® (21st annual edition) 2016
Ankle & Foot (updated 11/09/15)
Lateral Ligament Reconstruction
Recommended as indicated below. This RCT concluded that, in terms of recovery of the preinjury activity level, the long-term results of surgical treatment of acute lateral ligament rupture of the ankle correspond with those of functional treatment. Although surgery appeared to decrease the prevalence of reinjury of the lateral ligaments, there may be an increased risk for the subsequent development of osteoarthritis. Surgical treatment comprised suture repair of the injured ligament(s) within the first week after injury, and a below-the-knee plaster cast was worn for six weeks with full weightbearing. Functional treatment consisted of the use of an Aircast ankle brace for three weeks. (Pihlajamäki, 2010) According to a Cochrane review, there is insufficient evidence to support any one surgical intervention over another surgical intervention for chronic ankle instability, but it is likely that there are limitations to the use of dynamic tenodesis. (de Vries, 2011) Functional treatment is preferred over surgical therapy for lateral ankle injury, but surgical treatment can be considered on an individual basis. (Kerkhoffs, 2012) See also Surgery for ankle sprains; & Allograft for ankle reconstruction.
ODG Indications for Surgery -- Lateral ligament ankle reconstruction:
Criteria for lateral ligament ankle reconstruction for chronic instability or acute sprain/strain inversion injury:
1. Conservative Care: Physical Therapy (Immobilization with support cast or ankle brace & Rehab program). For either of the above, time frame will be variable with severity of trauma. PLUS
2. Subjective Clinical Findings: For chronic: Instability of the ankle. Supportive findings: Complaint of swelling. For acute: Description of an inversion. AND/OR Hyperextension injury, ecchymosis, swelling. PLUS
3. Objective Clinical Findings: For chronic: Positive anterior drawer. For acute: Grade-3 injury (lateral injury). [Ankle sprains can range from stretching (Grade I) to partial rupture (Grade II) to complete rupture of the ligament (Grade III).1 (Litt, 1992)] AND/OR Osteochondral fragment. AND/OR Medial incompetence. AND Positive anterior drawer. PLUS
4. Imaging Clinical Findings: Positive stress x-rays (performed by a physician) identifying motion at ankle or subtalar joint. At least 15 degree lateral opening at the ankle joint. OR Demonstrable subtalar movement. AND Negative to minimal arthritic joint changes on x-ray.
Procedures Not supported: Use of prosthetic ligaments, plastic implants, calcaneus osteotomies. (Washington, 2002) (Schmidt, 2004) (Hintermann, 2003)
For average hospital LOS if criteria are met, see Hospital length of stay (LOS).
Immobilization

Not recommended as a primary treatment. Early mobilization, functional treatment and partial weight bearing as tolerated appear to be a favorable treatment strategy for acute ankle sprains when compared with immobilization. However, for patients with a clearly unstable joint: immobilization may be necessary for 4 to 6 weeks, with active and/or passive therapy to achieve optimal function. (Kerkhoffs-Cochrane, 2002) (Shrier, 1995) (Colorado, 2001) Immobilization and rest appear to be overused as treatment. Early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications. (Nash, 2004) Functional treatment for severe ruptures of the lateral ankle ligaments leads to better results than cast immobilization for six weeks. (Pijnenburg, 2000) After surgical reconstruction for chronic lateral ankle instability, early functional rehabilitation was shown to be superior to six weeks immobilization regarding time to return to work and sports. (de Vries-Cochrane, 2006) Comparisons of surgically and nonsurgically treated Achilles tendon ruptures have demonstrated that those treated with surgery allow earlier motion and tend to show superior results. However, early motion enhances tendon healing with or without surgery and may be the important factor in optimizing outcomes in patients with Achilles tendon rupture. This RCT supports early motion (progressing to full weightbearing at 8 weeks from treatment) as an acceptable form of rehabilitation in both surgically and nonsurgically treated patients with comparable functional results and a low rerupture rate. (Twaddle, 2007) After ankle fracture surgical fixation, commencing exercise in a removable brace or splint significantly improved activity limitation but also led to a higher rate of adverse events. Because of the potential increased risk, the patient's ability to comply with this treatment regimen is essential. (Lin, 2009) According to this systematic review of treatment for ankle sprains, for mild-to-moderate ankle sprains, functional treatment options (which can consist of elastic bandaging, soft casting, taping or orthoses with associated coordination training) were found to be statistically better than immobilization for multiple outcome measures. (Seah, 2011) According to a Cochrane review, after surgical reconstruction, early functional rehabilitation appears to be superior to immobilization in restoring early function. (de Vries, 2011) While a short period of plaster immobilization or similar rigid support can be helpful in the acute phase of the treatment of lateral ankle injury in facilitating a rapid decrease of pain and swelling, functional treatment for 4 to 6 weeks is preferable to immobilization after that short period. (Kerkhoffs, 2012) New guidelines for treating and preventing ankle sprains in athletes call for functional rehabilitation rather than immobilization for grade I and II sprains, and prophylactic ankle supports for athletes with a history of previous ankle sprains. Grade III sprains should be immobilized for at least 10 days with a rigid stirrup brace or below-knee cast and then controlled therapeutic exercise instituted. (Kaminski, 2013)