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**DATE OF REVIEW: 8/14/2018**

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

Medical necessity of “1 left ankle arthroscopy with extensive debridement, possible arthrotomy, ATF ligament repair, Talar arthroscopy, decompression of superficial peroneal nerve, lateral compartment decompression and neuroplasty ankle” for the patient.

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

M.D. Board Certified in Orthopedic Surgery and Sports Medicine.

**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)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a XXXX with a history of a work-related injury to XXXX left ankle on XXXX. According to the available clinic notes XXXX continues to have pain in both ankles but the left is the worst and the subject of this claim. XXXX has pain and instability in the ankle according the notes. XXXX has been treated with some type of bracing that is not specified, medications, rest, and PT. On exam XXXX is noted to have tenderness and swelling with the location not specified other than it being noted that palpation over the superficial peroneal nerve at an unspecified location causes electric shock type pains. This apparently mostly improved with a local injection at an unspecified location. XXXX is noted to have instability with anterior drawer testing. No x-rays or stress x-rays are discussed. XXXX has had an MRI that showed an apparent tear of the anterior talofibular ligament and a partial tear of the posterior talofibular ligament. No intra-articular pathology or any other abnormalities were noted. There appears to have been some concern about XXXX peroneal nerve and a compartment syndrome in the lateral compartment. XXXX EMG, however, show no abnormality with nerve conduction tests and appears to demonstrate an L5 radiculopathy on both sides and not just a peroneal nerve issue. There is no documentation of compartment pressure testing or of specific activity related lateral compartment pain to support XXXX having a compartment syndrome. The request at this point is for a left ankle scope vs arthrotomy with debridement, ATFL repair, Talar arthroscopy, and decompression of the lateral compartment and SPN which has been non-certified twice previously due to lack of objective imaging evidence of ankle instability, lack of objective evidence of SPN dysfunction, and due to some uncertainty of the source of the patient’s persistent symptoms given the findings of radiculopathy.

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

Per ODG references the requested “1 left ankle arthroscopy with extensive debridement, possible arthrotomy, ATF ligament repair, Talar arthroscopy, decompression of superficial peroneal nerve, lateral compartment decompression and neuroplasty” is not medically necessary. There is no stress imaging done to objectively assess Talar or subtalar motion as is required by the ODG guidelines to consider surgery. XXXX does not have evidence of intra-articular, sinus tarsi, or subtalar pathology on MRI so there is no objective evidence to support the arthroscopy requests. The source of XXXX symptoms is in question given the EMG findings supporting a radiculopathy as opposed to any SPN specific issues. For these reasons, there is not sufficient evidence to support the requested surgical procedures at this time, so the request is not approved. There is no objective evidence of ankle instability based on radiographs and the ankle exams mentioned in these notes say XXXX had no instability.

**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 KNOWLEDGE BASE
- 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