Health Decisions, Inc.

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX ankle XX and Repair XX, XX, and XX

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

Board Certified in Orthopedic Surgery

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.

PATIENT CLINICAL HISTORY [SUMMARY]: XXXX. XXXX has had an MRI and an x-ray and XXXX provider is now requesting a XX ankle XX and repair. The insurance company is denying these services.

XXXX – X-Ray Results- **XXXX**: Indication: XX ankle injury. 3 views of the XX ankle. Findings: The XX and XX joints are intact. No acute fractures are seen. The XX dome is unremarkable. No foreign bodies are seen. The soft tissues are intact. Impression: There are no radiographically evident acute abnormalities of the XX.

XXXX – MRI Results- XXXX: MRI of the XX ankle without intravenous contrast. Clinical History: XX XX pain following work-related injury XXXX. No prior XX XX XX indicated on the history/screening form. Impression: 1) Peroneal XX, XX strain and XX with XX appearing XX.0cm peroneus XX XX XX XX between the XX/XX XX malleolus and the XX margin of the XX tarsi. No fluid-filled XX XX XX or tendon XX. 2) Mild to moderate XX and non-insertional XX XX with XX XX XX of the XX/XX third of less than XX% tendon thickness. XX XX insertion is intact. Trace XX XX fluid. Flexor and extensor tendons are intact. 3) Subtle midline posterior XX marrow XX without fracture. No marrow contusion or fracture involving the

remainder of the XX ankle. No XX lesion of the XX. 4) Mild increased XX and XX joint XX, suggestive of XX. 5) XX appear intact. No imaging evidence of XX XX XX or XX XX.

XXXX – Physician Notes- XXXX: Orthopedic Note. Chief Complaint: XX ankle injury. History: XXXX. XXXX developed pain and XX, went to XXXX. XXXX eventually went to XXXX due to persistent pain. Most of the pain is at the XX aspect of XXXX ankle. XXXX has also had XX in this area with associated pain. XXXX has XX XX this ankle before. XXXX has been XX an XX XX. XXXX is taking pain medication as needed. Physical Examination: The patient's vital signs are XX. XXXX is XXXX. XXXX XX on XXXX XX XX XX with an XX gait with an XX XX. There is XX alignment. The XX is intact. There is XX around the XX XX in the XX XX region. There is also some XX at the XX aspect of the ankle. The XX XX is intact. The XX XX are stable to foot XX with some XX. There is XX ankle range of motion. There is no gross XX to XX drawer or XX XX testing. Light touch is XX, and there are good XX pulses. Imaging: MRI of the XX ankle shows a XX in the XX XX XX with some surrounding XX. There is some XX XX and an ankle XX. Plan: I went over the findings at length with the patient. We discussed non-operative versus operative treatment. XXXX is clearly XX XX to non-operative management. We talked about an ankle XX with treatment of intra-XX pathology as needed and a XX XX XX repair. The risks and benefits of surgery were discussed in detail. The risks include but are not limited problems with XX, XX, wound XX, XX injury, XX XX, and XX XX. XXXX understands discussion and wishes to proceed. We will schedule the surgery as soon as possible. In the meantime, XXXX will continue with XXXX work restrictions, XX and pain medication as needed.

XXXX – Physician Notes- XXXX: History: The patient is here to follow up on XXXX XX ankle injury that XXXX sustained on the job, XXXX. XXXX feels like the pain in the ankle is XX. XXXX continues to try to work regular duty. XXXX has taken XX for pain. XXXX has also tried an ankle XX. We talked about surgery at XXXX last visit. Apparently, XXXX surgery was not approved by XXXX insurance. XXXX is XX XX at this point. Review of Systems: All other systems has been reviewed and found to be negative. Physical Exam: The patient XX on XXXX XX XX XX with an XX gait. XXXX vital signs are XX. There is XX along the course of the XX XX near the XX groove region, but there is also some XX XX along the XX aspect of the ankle. XXXX has limited XX ankle XX, XX, XX and XX due to pain. The XX XX is intact. The XX is intact. There is no gross XX to XX drawer or XX tilt testing. Light touch is intact with good XX XX. Plan: I went over the findings at length with the patient. XXXX will be placed into a XX for XX. XXXX will continue with XX-XX medication as needed for pain. XXXX will be placed on work restrictions. We again talked about a XX ankle XX examination with treatment of intra-articular pathology as needed as well as a XX XX repair due to XXXX persistent pain and inability to respond to non-operative management. XXXX would like to proceed with surgery as soon as possible.

XXXX – URA Determination- XXXX: Notification of Adverse Determination: Requested Service(s): XX ankle XX and repair XX, XX, and XX. Request Received Date: XXXX. XXXX. for the provision of services through a network for the work related injury of XXXX. On behalf of XXXX network a physician advisor review has been completed by XXXX. Reviewer Comments (Clinical Basis for Determination): XXXX; XXXX developed pain and XX. The x-ray of the XX ankle by XXXX, documented no XX evident acute abnormalities of the ankle. The

MRI of the XX ankle by XXXX, documented XX XX, XX XX and XX with XX appearing XX XX XX XX XX split between the XX XX XX and the XX margin of the XX XX. Mild to moderate XX and non-insertional XX XX with XX XX XX of the XX/XX third of less than XX% XX thickness. Trace XX XX fluid. Subtle XX XX XX XX XX without fracture. Mildly increased XX and XX XX fluid suggestive of XX. According to the orthopedic note by XXXX, the patient complained of worsening XX XX pain. XXXX has taken XX for pain. The dosage and frequency were not documented during the visit. XXXX has also tried an ankle XX. They talked about surgery at XXXX last visit. Apparently, XXXX surgery was not approved by XXXX insurance. XXXX was very frustrated at this point. On physical examination, the patient XX on XXXX XX XX XX with an XX gait. XXXX vital signs were stable. There was XX along the course of the XX XX near the XX XX region, but there was also some diffuse XX along the XX aspect of the ankle. XXXX had XX XX ankle XX, XX, XX and XX due to pain. The XX XX was intact. The XX was intact. There was no gross laxity to an anterior drawer or talar tilt testing. Light touch was intact with good distal pulses. Per plan, XXXX would be placed into a XX for comfort. XXXX would continue with anti-inflammatory medication as needed for pain. XXXX would be placed on work restrictions. They discussed a XX ankle XX examination with the treatment of XX-XX pathology as need as well as a XX XX repair due to XXXX persistent pain and inability to respond to non-operative management. XXXX would like to proceed with XX as soon as possible. The current request is XX ankle XX and repair XX, XX, XX. Primary Reason(s) for Determination: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines, this request is non-certified. Per medical report dated XXXX, the patient complained of worsening XX XX pain. Examination showed XX gait, tenderness along the course of the XX XX near the XX groove region but there was also some diffuse XX along the XX aspect of the XX. XXXX had limited XX ankle XX, XX, XX and XX due to pain. However, the objective findings were limited to validate the need for surgery. Additionally, there was no clear evidence of exhaustion of conservative treatments.

XXXX – URA Re-Determination- XXXX: Notification of reconsideration adverse determination: The reconsideration of our medical determination regarding treatment ordered on behalf of XXXX was received on XXXX. The reconsideration was referred to a Texas Licensed Utilization Review Physician for XXXX, who was not involved in the original review determination. The review of this reconsideration has been completed. After careful review of all available information, our Texas Licensed Utilization Review Physician has determined that the proposed treatment does not meet medical necessity guidelines. We are unable to recommend the proposed treatment based on the following: Recommendations: Is XX ankle arthroscopy and repair XX XX XX medically necessary? Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines, this request is non-certified. The objective clinical findings presented were limited to support the need for the requested intervention. A more thorough physical examination including an assessment of ligament integrity with quantifiable findings must be presented to support the diagnosis. There were also limited findings suggestive of functional deficits and activity limitations precluded by XXXX XX ankle complaints. Moreover, an evidence that the patient had exhausted or failed or was unresponsive to XXXX non-operative treatments before considering this procedure was not fully established. Clarification is need regarding the request and how it might affect the patient's clinical outcomes. Exceptional factors were not identified.

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

The request for XX ankle surgery is approved, in part: the XX XX repair is approved and the ankle XX is denied.

This patient sustained a XX ankle injury in XXXX. The XXXX MRI of the XX ankle identified a XX XX split in the XX XX XX. XXXX also had XX XX and XX XX in the XX joint.

On examination, XXXX has XX around the XX tendons in the XX-XX XX. XXXX has XX ankle motion, secondary to pain. XXXX ankle is stable on examination. The treating physician has recommended XX of the XX ankle and repair of the XX XX XX. Any intra-articular pathology identified on arthroscopic examination would be addressed at the time of surgery.

1. Peroneal tendon repair: The Official Disability Guidelines (ODG) recommends tendon repair for the treatment of large XX of the XX XX. Conservative care can be considered for XX.

The patient sustained a XX XX more than XXXX. Based on the patient's XXXX examination, the XX XX is XXXX primary source of pain. At this point, it is unlikely that any additional conservative care will facilitate healing of the XX. Repair of the XX is medically necessary.

2. Ankle XX: The ODG supports ankle XX for the treatment of the following diagnoses: ankle XX, XX lesions, and to assist ankle XX. There is insufficient evidence to support ankle XX for XX.

The patient has no significant XX-XX pathology identified on MRI. XXXX does not require an ankle XX.

ODG Guidelines:
XX

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)**