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Description of the service or services in dispute:
Right ankle arthroscopy plus compression device and walking / surgical boot.

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified Orthopedic Surgery

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

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

Patient Clinical History (Summary)
XXXX is a XXXX who was diagnosed with a fracture of posterior malleolus, synovitis and / or tenosynovitis of the right ankle / foot, fracture of the right ankle and pain in the right leg.

On XXXX, XXXX sustained an injury to the right lower extremity.

XXXX was seen on XXXX by XXXX (Foot and Ankle Surgery) for a right ankle fracture. XXXX complained of ankle pain with walking and daily activity. The associated symptoms were weakness, numbness, tingling, swelling, catching / locking and popping / clicking, which radiated down the leg. On examination, XXXX had an antalgic gait. There was compensating right flatfoot. Bony palpation of the right ankle / foot revealed tenderness in the medial ankle, lateral ankle, gutter ankle, the calcaneal tuberosity, the navicular tuberosity, the dome of the talus, the head of the talus, the inferior tibiofibular joint and the Achilles tendon insertion. Clicking and catching were noted. There was a painful range of motion of the right ankle. Soft tissue palpation of the right ankle / foot showed tenderness of the sinus tarsi, the anterior talofibular ligament, the calcaneofibular ligament, the posterior talofibular ligament, the peroneal retinaculum and the deltoid ligament. There was decreased range of motion of the subtalar. Right ankle examination showed anterior drawer of grade 1+ and talar tilt of grade 2+. Anterior drawer test and talar tilt test elicited pain and instability, ankle eversion test showed deltoid ligament complex abnormal, clunk test showed distal tibial-fibular ligament complex positive and squeeze test showed tibial-fibular diastasis pain.

An MRI of the right ankle performed on XXXX showed a nondisplaced fracture involving the posterior malleolus, with bone marrow edema and overlying soft tissue edema. A CT of the right ankle was performed on XXXX, which showed complete healing of the posterior medial malleolar fracture. There was a small amount of fracture plane persisting along the intra-articular component, which spanned the majority of the medial to lateral dimension of the prior fracture. No dislocation was noted. Small os

trigonum and tiny talar beaking were present. Small deep Achilles tendon surface ganglion cyst measuring 5 mm, was again identified.

Treatment to date included medications (XX). An additional progress note dated XXXX the treating provider indicate ongoing complaints of ankle pain with prolonged standing. The examination noted evidence of midfoot plaintiffs and hallux valgus with compensatory flatfoot. Tenderness over the medial lateral aspect ankle as well as calcaneal tuberosity, navicular tuberosity, and dome of the talus was noted. Tenderness was also documented at the Achilles tendon insertion with palpable clicking, catching, and painful range of motion of the tibiotalar joint. Tenderness to palpation was also noted along the sinus tarsi. Anterior drawer test and talar tilt test were both positive. The provider notes that symptoms improved previously with the ankle joint injection bracing. Arthroscopic debridement was recommended. The provider concedes that the ODG criteria for custom orthotics have not been met but opines that this intervention would benefit the injured worker. The XXXX podiatry visit notes no significant change in objective examination findings and recommends custom orthotics again. The provider notes that the injured worker is likely to proceed with operative intervention. The provider continues to indicate that the custom orthotics may allow for avoidance of surgical intervention, but then goes on to recommend surgical intervention.

A peer review completed by XXXX (Orthopedic Surgery) on XXXX, stated that XXXX sustained a posterior malleolus fracture of XXXX right ankle as a result of XXXX work injury. There was no evidence in the record that XXXX sustained any significant injury to XXXX left or right shoulder or right knee. XXXX might have also sustained a left rib contusion. According to XXXX, the extent of injury was only mild strain / contusion of the other body parts, as well as a nondisplaced fracture of the posterior malleolus. The diagnoses appeared to be related to work injury. XXXX opined that the compensable injury had already resolved. XXXX likely had a minimal, nondisplaced posterior labrum tear, due to some minor prior trauma. There was no evidence that the pre-existing condition was aggravated, accelerated or exacerbated in any way by the work injury. Per XXXX, XXXX ongoing medial status was postoperative left shoulder labral debridement. XXXX had no objective findings to support XXXX ongoing subjective complaints. Nothing was found on the right knee MRI. Minimal findings were found in the shoulder, and XXXX did have an ankle fracture which was healed, by CT scan examination, without complications. However, XXXX continued to complain of pain in all body parts without any objective support for XXXX subjective complaints of pain. Based on the review of the medical documentation and Official Disability Guidelines (ODG), no further treatment was indicated for any body part as a result of XXXX work injury. The right ankle had healed, no significant findings were found in the left shoulder, and the right knee was found to be uninjured. Therefore, no further treatment was indicated for the ankle, as the fracture had healed, and the patient had undergone appropriate physical therapy. No further treatment was indicated. Official Disability Guidelines (ODG) supported the need for 12 physical therapy visits over 12 weeks for treatment of XXXX posterior malleolus fracture. With respect to XXXX left shoulder surgery, Official Disability Guidelines (ODG) had no specific recommendations for labral debridement. In XXXX's opinion, six to eight visits, followed by a home exercise program, of physical therapy following a labral debridement would be reasonable and necessary. Any treatment outside of those guidelines would have exceeded Official Disability Guidelines (ODG). Treatment did not appear to be unrelated to the accident, with the exception of the labral surgery and postsurgical labral tear, which, in XXXX's opinion, was due to a pre-existing condition. Additionally, it was opined that no surgery was indicated, in any way, for XXXX left shoulder condition. According to XXXX, there was no indication for any type of right ankle surgery. The CT scan that was performed disclosed routine healing of the posterior malleolus fracture. XXXX also diagnosed routine healing following the posterior malleolus fracture. The records did not support the need for any type of surgery on the right ankle.

A utilization review determination letter dated XXXX by XXXX (Orthopedic Surgery) indicated that the request for right ankle arthroscopy plus compression device and walking / surgical boot was denied. Rationale: "XXXX noted to have sustained a right lower extremity injury on XXXX. The clinical records presented for review begin with a copy of an enhanced imaging study of the right ankle noting a nearly completely healed posterior medial molecular fracture. A small component of fracture is also reported. The progress note dated XXXX note this XXXX individual to have ongoing weakness in the distal right lower extremity. The findings on CT scan of the ankle are noted. The pain level continues to be 5/10. The physical examination notes tenderness to palpation over the medial aspect of the ankle. An element of instability is reported, as there is a positive anterior drawer sign. The clinical assessment is a fracture of ankle and the posterior malleolus. The clinical assessment completed on XXXX notes ongoing complaints of right ankle pain and some pain associated with ambulation. There continues to be some tenderness to palpation. It is reported there was a nonunion company ankle fracture. The CT scan obtained several months previous noted a near-complete heel fracture. The podiatrist feels there is a nonunion of the fracture, however, there are no radiographic reports indicating such a pathology exists. The physical examination does not support a nonunion, therefore, this is a lack of specific objective data this is not clinically indicated."

A reconsideration letter dated XXXX by XXXX (Neurosurgery) indicated that the request for right ankle arthroscopy plus deep venous thrombosis unit, walking boot, postoperative splint, lower leg cast, cast shoe and custom orthotics were denied. Rationale: "An MRI of the right ankle was obtained on XXXX, noting a nondisplaced fracture of the posterior malleolus with bone marrow edema. The remainder of the ankle is within normal limits. There is no widening of the joint reported. A follow-up assessment was completed on XXXX, noting a nearly completely healed posterior medial malleolus fracture. Documentation from the nurse case manager dated XXXX, indicates ongoing complaints of ankle pain. Also noted were complaints of shoulder pain. It is noted a request for surgical intervention was not certified in the utilization review process. An additional requested surgical intervention was not certified in the utilization review process. An additional requested surgical intervention is noted, the progress note dated XXXX notes the diagnosis as a right ankle fracture. The vital signs note a XXXX individual to have ongoing complaints of ankle pain. A burning sharp pain is reported. The injured employee is currently working a light duty status. The physical examination noted some tenderness to palpation. No specific neurologic loss is identified. Plain radiographs were obtained, it is reported there are arthritic changes. The injured individual declined obtaining a second surgical opinion and endorsed ongoing conservative care. A podiatry evaluation reports posterior ankle arthritic changes, with tenderness to palpation in this region. A surgical intervention is suggested. The reference to the MRI scan notes a near-completely healed the posterior medial malleolar fracture. Constant orthotics are suggested. The enhanced imaging studies documented a near-healed fracture. The follow-up assessment in the podiatry office suggested arthritic changes and a step-off; however, neither the films are presented for review, nor is there a radiologist assessment of the findings noted. Furthermore, there is some contradictory information relative to the endorsement of a surgical intervention by the injured employee wishing to pursue conservative care or not. Therefore, there is insufficient clinical data presented to suggest the need for this surgical intervention. Additionally, there is no clinical indication for a deep venous thrombosis unit, custom orthotics and lower extremity cast and cast shoe. The determination that this is not clinically indicated is unchanged."

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The ODG supports the use of ankle arthroscopy and recommends diagnostic arthroscopy with particular assessment after ankle fracture or ankle sprain as necessary. However, the documentation available clearly indicates a negative MRI on XXXX. The previous peer review indicates no objective findings which would account for the current symptoms and ongoing pain complaints. The podiatrist continues to

recommend ankle arthroscopy for debridement of a lesion, but no specific lesion was identified on imaging. An ongoing recommendation for custom orthotics are noted despite the ODG recommendation otherwise. Given the information available, the original denial for the surgical intervention, compression device, and postoperative surgical boot would be consistent with ODG criteria and the information available. A recommendation is made to uphold the original denials. Given the documentation available, the requested service(s) is considered not medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

☐ ACOEM-America College of Occupational and Environmental Medicine

☐ AHRQ-Agency for Healthcare Research and Quality Guidelines

☐ DWC-Division of Workers Compensation Policies and 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 and Treatment Guidelines

Diagnostic Arthroscopy:

Recommended as indicated below for symptomatic non-arthritic knee conditions following appropriate conservative care. Second look arthroscopy is only recommended for complications following osteochondral autograft transplant system or autologous chondrocyte implantation procedures or for individual cases that are ethically defendable for scientific reasons, only after a thorough and full informed consent procedure. (Vanlauwe, 2007)

See also Arthroscopic surgery for osteoarthritis and Chondroplasty.

ODG Indications for Surgery
Criteria for diagnostic arthroscopy:
1. Conservative Care: A minimum of 6 weeks, including medications AND/OR physical therapy AND/OR bracing. PLUS
2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS
3. Imaging Clinical Findings: Inconclusive imaging AND absence of moderate-to-severe arthritic changes. (Washington, 2003b) (Lee, 2004)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

Although the indications supporting arthroscopy for patients with osteoarthritis remain limited, the ability of MRI to precisely grade cartilage loss is less accurate than diagnostic arthroscopy. Should the assessment of cartilage quality be crucial for definitive decision-making regarding therapeutic options in patients with mild osteoarthritis, then diagnostic arthroscopy may be appropriate. The diagnostic values of MRI grading, using arthroscopy as a reference standard, were calculated for each grade of cartilage damage. For grade 1, 2, and 3 lesions, sensitivities were relatively poor, whereas relatively better values were noted for grade 4 disorders. (von Engelhardt, 2010)

Orthotic Devices:

Recommended for plantar fasciitis and for foot pain in rheumatoid arthritis. See also Prostheses (artificial limb). Both prefabricated and custom orthotic devices are recommended for plantar heel pain (plantar fasciitis, plantar fasciosis, heel spur syndrome). (Thomas, 2010)

See also Ankle foot orthosis (AFO); IDEO™ (intrepid dynamic exoskeletal orthosis).

Orthoses should be cautiously prescribed in treating plantar heel pain for those patients who stand for long periods; stretching exercises and heel pads are associated with better outcomes than custom made orthoses in people who stand for more than eight hours per day. (Crawford, 2003) As part of the initial treatment of proximal plantar fasciitis, when used in conjunction with a stretching program, a prefabricated shoe insert is more likely to produce improvement in symptoms than a custom polypropylene orthotic device or stretching alone. The percentages improved in each group were: (1) silicone insert, 95%; (2) rubber insert, 88%; (3) felt insert, 81%; (4) Achilles tendon and plantar fascia stretching only, 72%; and (5) custom orthosis, 68%. (Pfeffer, 1999) Evidence indicates mechanical treatment with taping and orthoses to be more effective than either anti-inflammatory or accommodative modalities in the treatment of plantar fasciitis. (Lynch, 1998) (Gross, 2002) For ankle sprains, the use of an elastic bandage has fewer complications than taping but appears to be associated with a slower return to work, and more reported instability than a semi-rigid ankle support. Lace-up ankle support appears effective in reducing swelling in the short-term compared with semi-rigid ankle support, elastic bandage and tape. (Kerkhoffs, 2002) For hallux valgus the evidence suggests that orthoses and night splints do not appear to be any more beneficial in improving outcomes than no treatment. (Ferrari-Cochrane, 2004) Semirigid foot orthotics appear to be more effective than supportive shoes worn alone or worn with soft orthoses for metatarsalgia. (Chalmers, 2000)

The use of shock absorbing inserts in footwear probably reduces the incidence of stress fractures. There is insufficient evidence to determine the best design of such inserts but comfort and tolerability should be considered. Rehabilitation after tibial stress fracture may be aided by the use of pneumatic bracing but more evidence is required to confirm this. (Rome-Cochrane, 2005) Foot orthoses produce small short-term benefits in function and may also produce small reductions in pain for people with plantar fasciitis, but they do not have long-term beneficial effects compared with a sham device. The customized and prefabricated orthoses used in this trial have similar effectiveness in the treatment of plantar fasciitis. (Landorf, 2006) Eleven trials involving 1332 participants were included in this meta-analysis: five trials evaluated custom-made foot orthoses for plantar fasciitis (691 participants); three for foot pain in rheumatoid arthritis (231 participants); and one for hallux valgus (209 participants). Custom-made foot orthoses were effective for rearfoot pain in rheumatoid arthritis (NNT:4) and painful hallux valgus (NNT:6); however, surgery was even more effective for hallux valgus. It is unclear if custom-made foot orthoses were effective for plantar fasciitis or metatarsophalangeal joint pain in rheumatoid arthritis. (Hawke, 2008) Rocker profile shoes are commonly prescribed based on theoretical considerations with minimal scientific study and validation. Rocker profiles are used to afford pressure relief for the plantar surface of the foot, to limit the need for sagittal plane motion in the joints of the foot and to alter gait kinetics and kinematics in proximal joints. In this review, efficacy has not been demonstrated. The effectiveness of rocker-soled shoes in restricting sagittal plane motion in individual joints of the foot is unclear. Rocker profiles have minimal effect on the kinetics and kinematics of the more proximal joints of the lower limb, but more significant effects are seen at the ankle. (Hutchins, 2009)

According to this systematic review of treatment for ankle sprains, pneumatic braces provide beneficial ankle support and may prevent subsequent sprains during high-risk sporting activity. (Seah, 2011) In

reducing the risk of plantar fasciitis at work, the use of shoe orthoses with a medial longitudinal arch and metatarsal pad may be used as a preventive or treatment strategy. (Werner, 2010) Outcomes from using a custom orthosis are highly variable and dependent on the skill of the fabricator and the material used. A trial of a prefabricated orthosis is recommended in the acute phase, but due to diverse anatomical differences many patients will require a custom orthosis for long-term pain control. A pre-fab orthosis may be made of softer material more appropriate in the acute phase, but it may break down with use whereas a custom semi-rigid orthosis may work better over the long term. See also Ankle foot orthosis (AFO).

Bilateral orthotics: Bilateral foot orthotics/orthoses are not recommended to treat unilateral ankle-foot problems. (Song, 2009) See Limb length temporary adjustment device, where a heel/sole lift is recommended when it is necessary to balance the limb lengths from use of an orthotic device that will add more than 2 cm length to one lower extremity for a long duration.

- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.