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***Review Outcome***

***Description of the service or services in dispute:***

Right ankle arthroscopy with ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partial (29895 & 29898); peroneal tendon repair/tenolysis and modified Brostrom procedure.

***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)***

XX who was diagnosed with right ankle instability (M25.371) and right peroneal tenosynovitis (M65.871). The additional diagnoses included right ankle synovitis and right plantar fasciitis. XX sustained a right ankle injury XXXX

XX was evaluated by XX on XXXX for right ankle pain. Per the note, XX continued to have pain and swelling in the right ankle. XX also complained of ankle instability. XX underwent physical therapy. XX had tried bracing and anti-inflammatory medication. XX had developed some pain at the plantar aspect of the right heel. The pain was worse with activities and when XX would first stand in the morning. On the ankle examination, XX ambulated on XX right lower extremity with an antalgic gait. There was tenderness and swelling along the peroneal tendons near the retrofibular groove. There was some laxity in the anterior drawer and talar tilt testing with pain. XX was able to dorsiflex and plantarflex the ankle and toes. There was some restricted ankle motion due to the pain.

The treatment to date included bracing, anti-inflammatory medication, physical therapy and a home exercise program.

A right ankle MRI dated XXXX showed common peroneal tenosynovitis with contusion/stress change versus reactive bone marrow edema along the distal fibula with a grade-1 sprain of the peroneal retinaculum, mild Achilles paratenonitis and plantar fasciitis. An x-ray dated XXXX revealed no evidence of fracture, bony lesion or other significant osseous abnormalities.

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## ***Notice of Independent Review Decision***

Case Number: XXXXXX

Date of Notice: XXXX

Per a utilization review decision letter dated XXXX, the requested service was denied. The primary reason for determination was the requested service was not medically necessary. XX was a morbidly obese individual with ongoing complaints of ankle pain. There were no specific objective findings reported to support the surgical intervention. There were no stress films and the MRI did not identify any ligamentous compromise. Therefore, while noting the reported physical examination findings, there was insufficient objective clinical data presented to support this request. Accordingly, these requested services were not clinically indicated.

Per a utilization review decision letter dated XXXX, the requested services were not certified. Noting the specific parameters for a surgery on the lateral aspect of the ankle, there must be completion of conservative care. The records reflected a course of physical therapy had been completed. The injured individual felt there was some laxity/instability of the ankle. However, the physical examination did not identify a positive anterior drawer sign or a great 3 level injury. There were no stress bills presented to demonstrate the instability. The MRI of the lower extremity noted a synovitis of the common peroneal tendon. No other findings were presented. Therefore, understanding the length of time, this injury had been ongoing. There was no physical examination or objective diagnostic studies (flexion/extension, inversion/diversion stress views) completed to support the request for the surgery. Therefore, there was insufficient information presented to endorse this surgical intervention.

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

The ODG recommends the utilization of lateral ligament ankle reconstruction surgery for grade three ankle sprains with positive stress x-rays. The ODG recommends conservative treatment for peroneal tendinitis and surgery as an option for ruptured tendons. A grade three sprain involves full-thickness ligament tears. There is no indication that stress x-rays have been performed. The physical examination reveals some laxity with anterior drawer testing, but the provided MRI radiology report notes that the lateral ligament complex is intact, and there is common peroneal tenosynovitis without evidence of peroneal tendon rupture. There is no evidence of peroneal tendon dysfunction in the provided physical examination. Based on the documentation provided and the ODG recommendations, the utilization reviews completed on XXXX and XXXX were appropriate in recommending noncertification of the right ankle arthroscopy with partial synovectomy, peroneal tendon repair/tenolysis and modified Brostrom procedure.

### ***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 um knowledgebase

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- 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  
ODG, 2018: Ankle and Foot  
Surgery for ankle sprains  
Recommended as indicated below for Grade III sprains.

See also Lateral ligament 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 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).

Lateral ligament ankle reconstruction (surgery)

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Recommended as indicated below. See also Surgery for ankle sprains; & Allograft for ankle reconstruction.

ODG, 2018: Ankle and Foot

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).

Peroneal tendinitis/ tendon rupture (treatment) Recommend conservative treatment for tendinitis, and surgery as an option for a ruptured tendon.

Patients with peroneal tendonitis, but no significant peroneal tendon tear, can usually be treated successfully non-operatively. In patients with a large peroneal tendon tear or a bony prominence that is serving as a physical irritant to the tendon, surgery may be beneficial. Peroneal tendonitis is an irritation to the tendons that run past the back outside part of the ankle, and it is a common cause of lateral ankle pain. Commonly it is an overuse condition that responds to conservative treatment, but if it is left untreated it can progress to a complete tendon rupture. Predisposing factors for peroneal tendonitis and rupture include varus alignment of the hindfoot and peroneal subluxation and dislocation. Participation in certain sports, including downhill skiing, skating, ballet, running and soccer creates higher risk for peroneal tendon tears. If caught early, peroneal tendonitis or instability may be treated conservatively with NSAIDs, immobilization and avoidance of exacerbating activities. Once secondary changes in the tendon occur, however, surgical treatment often becomes

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necessary. Surgery is indicated in the acute phase for peroneus brevis tendon rupture, acute dislocation, anomalous peroneal brevis muscle hypertrophy, and in peroneus longus tears that are associated with diminished function. (Cerrato, 2009)

- 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)