

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0788-01  
IRO Certificate No.: 5259

February 18, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in orthopedic surgery. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by \_\_\_\_, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

\_\_\_ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to \_\_\_.

### CLINICAL HISTORY

\_\_\_ stepped in a hole and injured his foot and ankle. Within two months of the injury, an MRI was obtained. It was normal. A bone scan two weeks later was obtained. It was normal \_\_\_ became the treating physician of record and opined the patient had ankle pain. \_\_\_ notes from 10/2/03 through 12/30/03 were reviewed suggesting ill-defined and an inconsistent clinical presentation of any kind of lateral ankle pain. Plantar heel pain was noted on one occasion. Heel cups for bilateral heel pain were noted on the next clinical visit. Pain in the posterior aspect of the lateral ankle was noted. \_\_\_ on 12/23/03 found a positive drawer test \_\_\_ found a negative drawer test. This was almost concomitantly in the 12/23/03 and 12/30/03 visitations.

In a pre-authorization format, surgery was initially denied as being unnecessary. This was thought to be unnecessary relative to a lack of conservative treatment as well as documentation of the injury.

REQUESTED SERVICE (S)

Prospective medical necessity of the proposed left ankle exploration with repair of ligament and application of short leg case.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

This patient has an ill-defined seven-month history of a changing, alternating and inconsistent presentation of a left foot and ankle pain. The facts in this case are inconsistent between doctors and inconsistent with one doctor over time.

In reference to the Orthopedic Knowledge update, Home Syllabus VII where it defines ankle sprains the pathology and the appropriate medical treatment for Grade I, II and III injuries. Admittedly, some ankle sprains can produce chronic symptomatology. However, “mechanical instability needs to be ascertained.” to quote, “mechanical laxity should be clinically detectable by a standard anterior drawer test.” In this case, it is not. Stress radiography which was never obtained in this case could also be used as a differential. This was never obtained.

The diagnosis of lateral ankle ligament instability is poorly documented and even more inadequately treated. This patient does not need a Brostrom procedure or any ankle surgery at this point in time.

The opinions rendered in this case are the opinions of the evaluator. This evaluation has been conducted on the basis of the medical documentation provided with the assumption that the material is true, complete, and correct. If more information available at a later date, then additional services, reports, or reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment from the documentation provided.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
Texas Workers' Compensation Commission  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 19<sup>th</sup> day of February 2004.