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Notice of Independent Review Decision

IRO REVIEWER REPORT TEMPLATE –WC

November 26, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left ankle fusion/left ankle tarsal tunnel release

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

Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

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

☒ Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Diagnostics (05/08/06 – 06/14/12)
- Office visits (06/11/08 – 09/11/12)
- Utilization reviews (09/25/12, 10/31/12)

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- Utilization reviews (09/25/12, 10/31/12)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who injured her left ankle on xx/xx/xx, when she tried to avoid tripping over a cord while at work.

On May 8, 2006, the patient underwent magnetic resonance imaging (MRI) of the left ankle. The findings showed an 8 x 6 mm osteochondral lesion in the posteromedial talar dome. There was subchondral edema and cortical irregularity in this region.

On June 11, 2008, evaluated the patient. The patient was status post surgery on January 22, 2008, with arthrotomy, medial malleolus osteotomy and OATS graft with the graft taken from the left knee. She was attending therapy. She was at full work duties. She reported swelling at the end of a long day. Examination showed that the patient's wound was benign. At both left ankle and left knee there was no calf tenderness or ankle edema. She had regained her range of motion (ROM). recommended continuing therapy and ordered a sorbothane shoe insert.

On November 14, 2011, evaluated the patient for tarsal tunnel syndrome to the left ankle. The patient had undergone previous electromyography (EMG) in April 2011. At that time the distal motor latency for the left posterior tibial nerve across the tarsal tunnel was 6.8 with amplitude of 2.1 and conduction velocity of 38. On the opposite side, the conduction velocity was 49 with a distal motor latency of 5.6. The patient had healed from the previous surgery very well. She did not have significant changes in her symptoms which were numbness into the great toe, pain when she stood for any length of time and decreased sensation in the sole of her foot. performed EMG studies that showed no change in the conduction of the left posterior tibial nerve across the tarsal tunnel which might indicate intraneural soaring. There was no evidence of other entrapment neuropathy or radiculopathy in the left lower extremity on examination.

On June 13, 2012, evaluated the patient for left ankle pain. noted that following the injury the patient had swelling in her left ankle. Initially she was treated for ankle sprain. Later on she was seen who had diagnosed talar dome osteochondral defect. She was treated with multiple surgical procedures including microfracture of the talar dome, OATS procedures, with at least two of the procedures being done through a medial malleolus osteotomy. The patient did not feel like she had totally resolved. She still had pain in the distribution of the tarsal tunnel. She had numbness over her big toe, her second toe and over the medial aspect of her foot. The numbness would spread throughout the foot with dependence. She had pain with weightbearing through the ankle despite multiple surgeries. She had six left ankle surgeries, two left knee surgeries which she stated were for the OATS procedure graft and two left shoulder surgeries from previous injury. Examination of the left ankle showed multiple scars from previous incisions, minimal swelling throughout the foot and ankle, tenderness over the anteromedial ankle at the tibiotalar joint, tenderness along the tarsal tunnel with decreased sensation to Semmes-Weinstein monofilament along the medial aspect of the foot in the arch up to the first and second toes over the plantar aspect of those toes. Range of motion (ROM) of the tibiotalar joint was limited.

She had dorsiflexion up to neutral as what appeared to be a mechanical block due to the two spurs of the anterior tibia. There was 30 degrees of plantar flexion of the hindfoot. She had a positive Tinel's sign with tapping over the tarsal tunnel and pain radiating distally. X-rays of the left foot showed some arthritic changes in the tibiotalar joint with an anterior bone spur of the tibia. There were two screws in the medial malleolus, which were well fixed. There were degenerative changes throughout the tibiotalar joint. diagnosed chronic left foot and ankle pain and tarsal tunnel syndrome and recommended tarsal tunnel release.

On June 14, 2012, x-rays of the left foot showed very slight offset at the base of the second metatarsal and medial cuneiform, mild degenerative arthropathy in the first metatarsophalangeal joint and mild degenerative arthropathy in the tibiotalar joint. Clinical correlation for possible Lisfranc injury was recommended.

On September 11, 2012, evaluated the patient for left ankle pain. He noted that the ankle had become worse. Examination of the left ankle showed sharp pain up the leg on percussion over the tarsal tunnel, tenderness over the surgical incision medially, tenderness over the anterior medial ankle joint, mild swelling in the foot and ankle particularly medially, well-healed surgical scars and dorsiflexion to 5 degrees, plantar flexion to 25 degrees and stable ankle to inversion and eversion. diagnosed ankle pain, traumatic arthropathy of ankle or foot and tarsal tunnel syndrome. He recommended surgical intervention.

Per utilization review dated September 25, 2012; the request for left ankle fusion/tarsal tunnel release was denied based on the following rationale: "*After speaking with and reviewing the records available, the patient has had no treatment for her ankle other than a patch for greater than a year. Based on the guidelines which recommend conservative treatment to include immobilization, therapy and injections the request is recommended for non certification.*"

Per the reconsideration review dated October 31, 2012, the appeal for left ankle fusion/tarsal tunnel release was denied based on the following rationale: "*The patient has ankle pain with failure of multiple prior attempts to repair the ankle and tarsal tunnel. The patient has not had any recent injection to try to avoid surgery. Patient is just xx years old with morbid obesity. There was just mild arthritis on imaging. There was tarsal tunnel surgery that was already attempted that has failed. There were inadequate attempts to exhaustion of all conservative care measures to try to avoid surgery or delay it. Recommend non-certification of the request for left ankle fusion/tarsal tunnel release.*"

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

The claimant is a woman who was ongoing right foot and ankle problem following a 04/21/06 injury. The medical record provided for review goes from 05/08/06 through 09/11/12 documenting her complaints, findings, and treatment. These records document numerous ankle operations to include grafting as well as a

tarsal tunnel release. She has had ongoing pain and limitation in function, and a request is made for ankle fusion and tarsal tunnel release.

There have been two previous utilization reviews, dated 09/25/12 and 10/31/12, which appeared to indicate that surgical intervention is not necessary at this time. No further medical records were offered for review. This reviewer has gone over these records and agrees with the two prior utilization reviews. There is no recent documentation of conservative care, and there is no documentation that this claimant was ever placed in a cast to limit the motion of the ankle and see whether or not that in fact helped this person's symptoms.

Therefore, in light of the fact that is actually not clear what conservative care has been done recently, and there is no documentation of cast or brace immobilization to see whether or not that helped, then the requested surgical intervention at this time is not medically necessary.

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**