



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 10/11/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat MRI of left ankle

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Foot and Ankle Surgery

REVIEW OUTCOME

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

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

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Repeat MRI of left ankle - Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A Employee Injury and Treatment Form dated xx/xx/xx
An Employer's First Report of Injury or Illness form dated xx/xx/xx
X-rays of the thoracic spine and lumbar spine interpreted by M.D. dated 04/06/05
An evaluation with, M.D. dated 04/08/05
TWCC-73 forms from Dr. dated 04/08/05, 11/03/05, and 12/20/05
Physical therapy with, P.T. dated 04/12/05
Evaluations with, M.D. dated 04/14/05 and 11/03/05
A Physician Activity Status Report from Dr. dated 04/18/05
MRIs of the right shoulder and cervical spine interpreted by, M.D. dated 04/28/05
An evaluation with, M.D. dated 08/04/05
An LTI report from dated 08/29/05
A Required Medical Evaluation (RME) with, M.D. dated 09/27/05
X-rays of the left foot interpreted by, M.D. dated 09/30/05
An evaluation with, M.D. dated 11/07/05
Evaluations with, M.D. dated 11/08/05, 11/15/05, 12/20/05, 01/26/06, 03/03/06, 04/07/06, and 05/19/06
An MRI of the left ankle interpreted by, M.D. dated 11/11/05
DWC-73 forms from Dr. dated 01/26/06 and 05/29/06
An operative report from, M.D. dated 08/23/06
Evaluations with, P.T. dated 12/06/06 and 01/24/07
Letters from Dr. dated 05/01/07 and 08/02/07
A DWC-69 form from Dr. dated 05/01/07
An impairment rating evaluation with, D.C. dated 07/03/07
A DWC-73 form from Dr. dated 08/02/07
Evaluations with. M.D. dated 08/23/07 and 09/20/07
Preauthorization requests dated 08/30/07 and 09/12/07
A preauthorization report from R.N. at Management Services, Inc. dated 08/31/07
A letter of non-authorization, according to the ODG, from D.O. dated 08/31/07
A letter of non-authorization from, M.D. at Management Services, Inc. dated 09/14/07

PATIENT CLINICAL HISTORY

An Employer's First Report of Injury or Illness form dated xx/xx/xx revealed the claimant fell over a chair on xx/xx/xx and twisted her left foot and struck her back. X-rays of the thoracic and lumbar spine interpreted by Dr. on 04/06/05 revealed mild multilevel spondylosis with osteopenia in the thoracic spine and multilevel degenerative disc disease with osteopenia in the lumbar spine. On 04/08/05, Dr. recommended physical therapy. Physical therapy was performed with on 04/12/05. An MRI of the right shoulder interpreted by Dr. on 04/28/05 revealed degenerative changes of the AC joint, mild tendinopathy of the musculotendinous junction, and subacromial/subdeltoid bursitis. An MRI of the cervical spine interpreted by Dr. on 04/28/05 revealed degenerative disc changes at C6-C7 and moderate narrowing of the right neural foramen at C5-C6. On

08/04/05, Dr. recommended a left ankle sleeve brace and possible right shoulder surgery. On 09/27/05, Dr. recommended right shoulder surgery and a home exercise program with left ankle support for the ankle. X-rays of the left foot interpreted by Dr. on 09/30/05 were unremarkable. On 11/07/05, Dr. recommended right shoulder surgery. On 11/08/05, Dr. recommended a walker boot, an MRI of the ankle, and continuation of the ankle brace. An MRI of the left ankle interpreted by Dr. on 11/11/05 revealed mild tendinopathy and tenosynovitis, a partial tear/strain of the ATL, and moderate edema of the ankle. On 01/26/06, Dr. recommended therapy for the ankle. On 04/07/06, Dr. recommended a release to light work duty. Right shoulder surgery was performed by Dr. on 08/23/06. On 01/24/07, Ms. recommended physical therapy. On 05/01/07, Dr. placed the claimant at Maximum Medical Improvement (MMI) with a 7% whole person impairment rating. On 07/03/07, Dr. placed the claimant at MMI as of 06/27/07 with a 0% whole person impairment rating. On 08/23/07, Dr. recommended an MRI of the left foot. On 08/31/07, Ms. wrote a letter of denial for a repeat MRI of the left ankle. On 08/31/07, Dr. also wrote a letter of denial for the MRI. Dr. also wrote a letter of denial for the MRI on 09/14/07. On 09/20/07, Dr. recommended a subtalar arthrogram.

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

The period of time that has elapsed from her November 2005 MRI until now is a substantial amount of time for continued tendinopathy and degeneration of the posterior tibial tendon to have taken place, which would indicate that there is ongoing failure. Therefore, in my opinion, the repeat MRI may be very beneficial to the ultimate treatment of the claimant with regards to the requirements needed in her counseling, as well as operative procedure. Therefore, a repeat MRI of the left ankle is considered reasonable and necessary to substantiate if ongoing pathology is present in the claimant's foot.

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 AND KNOWLEDGE BASE
- 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)