

# Parker Healthcare Management Organization, Inc.

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**DATE OF REVIEW:** OCTOBER 18, 2007

**IRO CASE #:**

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Medical necessity of the proposed left ankle athroscopy with debridement (29898/ 27680/ 28120)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

## **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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
924.20	29898/ 28120		Prosp	1					Overturned
924.20	27680		Prosp	2					Overturned

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

TDI-HWCN-Request for an IRO-16

Respondent records- a total of 25 pages of records received to include but not limited to: letter, 9.28.07, 8.15.07, 8.7.07; ODG guidelines for surgery ankle sprains, noted in preauthorization letter for UR referral, not dated; notes, Dr. 4.16.07-7.25.07; MRI Lft ankle, 4.5.07;

Requestor records- a total of 47 pages of records received to include but not limited to:

Notes, Dr. 4.16.07-9.27.07; DWC form 69, 73; notes, PTC, 5.29.07-7.2.07; Center records, chest x-ray, 8.6.07, lab report, 8.6.07-8.9.07;

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained an on the job work related injury.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

The patient has failed non-operative treatment, which including bracing, rest, non-steriodal anti inflammatory drugs, etc. An MRI and evaluation are consistent with posterior impingement syndrome. He has evidence of tendosynovitis and synovitis. This has been going on since 03/25/2007. The requested procedure is medically indicated. The medical necessity is: Failure to improve with appropriate non-operative care and the presence of documented pathology and continuing dysfunction which can reasonably be expected to improve with surgical intervention.

**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 UM KNOWLEDGEBASE
- 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
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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

XX PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (Journal of the American Academy of Orthopedic Surgeons, Vol. 13, No. 6, 10/05: 365-371; Journal of Bone and Joint Surgery, 85: 1051-1057, 2003)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)