



Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 08/19/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left ankle arthroscopy with debridement and modified Brostrom lateral ligament reconstruction

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be :

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
71947	29898 27695		Prosp.	1	07/01/09 – 09/20/09				Overturn

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment
2. Letters of denial 07/07/09 and 07/27/09 including criteria used in the denial
3. MRI scan, 10/07/08
4. History and physical and assessment, 12/19/08 and 01/05/09
5. Orthopedic assessment and followup, 07/01/09 and 07/15/09

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient suffered a severe inversion injury to the left ankle on xx/xx/xx. Despite significant conservative treatment including bracing and physical therapy, the patient continued to have pain and instability. Surgery was denied by the insurance company twice due to the lack of stress x-rays or anterior drawer test. The patient was seen back by the orthopedic surgeon, and stress x-rays were obtained. An MRI scan was also obtained. These all demonstrated a grade 3 tear of the lateral ligament complex and significant instability.

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

The requesting orthopedic surgeon has fulfilled all the ODG criteria for ankle arthroscopy with debridement and lateral ligament reconstruction, mainly that of the stress x-rays that were brought up in both insurance denials. Based on additional information, surgery is medically reasonable and necessary for this patient.

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

INDEPENDENT REVIEW INCORPORATED

- 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.
 - Medical judgment, 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 national accepted medical literature (provide a description).
 - Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)
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