

I-Resolutions Inc.

An Independent Review Organization
8836 Colberg Dr.
Austin, TX 78749
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/03/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Ankle Arthroscopy Outpt 29895

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

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines

Care Guidelines

Denial Letters, 10/28/10, 11/11/10

Dr. OV 02/18/09, 03/18/09, 04/08/09, 10/22/10

MRI left foot 01/13/09

PATIENT CLINICAL HISTORY SUMMARY

This is a male claimant with a reported left ankle injury on xx/xx/xx when he slipped on some oil while getting out of a truck. Pain, swelling and bruising followed and a left ankle sprain was diagnosed. Initial treatment included pain medication and a walker boot. An MRI of the left foot performed on 01/13/09 showed no significant abnormality of the left foot.

Ongoing left anterolateral ankle and Achilles area pain was reported despite medication, a walker boot and physical therapy. A left ankle injection was given 03/18/09, which reportedly provided one-day of relief and then the pain returned. A follow up physician record noted the claimant with continued left ankle pain with some swelling and decreased motion. The diagnosis was left ankle sprain, left ankle synovitis and left insertional Achilles peritendinitis. A left ankle diagnostic and therapeutic arthroscopy was recommended.

A 10/22/10 physician record revealed the claimant with ongoing left ankle pain. Reportedly, the previous left ankle surgery request had been denied. Examination revealed continued pain anterolaterally left ankle with some swelling. Left ankle pain with continued pain, left

ankle synovitis and left anterolateral ankle impingement was diagnosed. Left ankle arthroscopic debridement was recommended.

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

This is a request for a left ankle arthroscopy. This has been previously denied on 10/18/10 and 11/11/10. Rationale for the first denial was that there was no clear and objective documentation regarding conservative treatment. The second request was also denied as it was felt that conservative care had not been exhausted and no additional information was provided. The patient has chronic ankle pain following an injury, xx/xx/xx. An MRI obtained 01/13/09 was normal with no significant abnormalities. X-rays obtained 02/18/09 by Dr. of the ankle and foot were felt to be unremarkable. Records reflect ongoing complaints of pain. Conservative measures have included antiinflammatory agents and physical therapy. On 03/18/09 a left ankle injection was given. On 04/08/09 it was noted that the patient had a day's relief from the injection, however, the pain returned. There is absence of records from 04/08/09 until 10/22/10 when the patient returned to Dr. with ongoing ankle pain. The patient was felt to have an antalgic gait in a brace with pain anterolaterally. There was no instability. There were no recent documented diagnostic studies. The patient's subjective complaints appeared rather excessive and the rationale for the procedure was poorly expressed in the information provided. The diagnostic studies did appear to have been normal. The reviewer finds that medical necessity does not exist at this time for Left Ankle Arthroscopy Outpt 29895.

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

ACOEM-AMERICA 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 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)