



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax:
877-738-4395

Notice of Independent Review Decision

DATE OF REVIEW: 08/09/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat CT scan of the 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 CT scan of the left ankle - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A CT scan of the left ankle without contrast dated 01/08/09 and interpreted by M.D.

Evaluations by M.D. dated 03/17/09, 04/22/09, 05/13/09, 06/10/09, 07/08/09, 08/11/09, 09/23/09, 10/07/09, and 07/06/11

A surgical report dated 05/04/09 from Dr

A request for physical therapy from Dr. dated 06/01/09

A physical therapy demographics form dated 06/01/09

An initial physical therapy evaluation from an unknown therapist (the signature was illegible) dated 06/01/09

A utilization review referral dated 06/16/11 from Dr. for x-rays of the left ankle

Another utilization review referral dated 07/02/11 from Dr. for a CT scan of the left ankle

Notifications of Utilization Review Determination, Inc. dated 07/14/11 from M.D.

Another Notification of Utilization Review Determination Inc. dated 07/21/11 from M.D.

A letter from, dated 07/28/11 addressed to the Texas Department of Insurance (TDI) at the HWCN Division

The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

A CT scan of the left ankle on 01/08/09 revealed postoperative changes in the left ankle with evidence of secondary degenerative joint disease. There was an old avulsion fracture at the tip of the lateral malleolus. There were also tiny osseous densities near the distal tibiofibular joint. It was noted if loose bodies were suspected, an MRI or CT arthrogram would be appropriate. Dr. evaluated the patient on 03/17/09. It was noted the patient had left ankle fracture sustained as an adolescent, but he noted he had no problems with the left ankle until the current injury. The patient was given an ankle sleeve and an intrarticular corticosteroid injection. The patient underwent left ankle arthroscopic debridement, extensive on 05/04/09 by Dr.. Dr. removed the sutures on 05/13/09 and asked the patient to continue in the walker boot and return in four weeks. The patient continued with pain and swelling in the left ankle with ambulation when he returned to Dr. on 06/10/09. Physical therapy was recommended and Celebrex was prescribed. On 08/11/09, Dr. stated the patient would return to full duty on 08/17/09 and he was asked to return in six weeks. On 10/07/09, Dr. noted the patient ambulated on his left lower extremity with a slightly antalgic gait using an ankle sleeve. Dr.

felt the patient had reached Maximum Medical Improvement (MMI) and noted his varus alignment from his childhood fracture could be causing the increased stress at the medial aspect of the ankle. It was felt realignment might be helpful. He was given work restrictions. The patient returned to Dr. on 07/06/11. He had persistent pain and stiffness and he stated he was never able to return to work. X-rays showed mild degenerative changes at the ankle joint and there was a varus deformity notes at the distal tibia. Dr. recommended a CT scan of the left ankle. On 07/14/11, Dr. provided a notice of adverse determination for the requested repeat CT scan of the left ankle. On 07/21/11, Dr. also provided a notice of adverse determination for the requested repeat CT scan of the left ankle.

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

The ODG states, "CT scan provides excellent visualization of bone and is used to further evaluate bony masses and suspected fractures not clearly identified on radiographic window evaluation." At this time, the ankle is not being evaluated for a suspected fracture or even a bony mass. A CT scan would not be expected to adequately evaluate the articular surfaces or soft tissues in the left ankle or provide more diagnostic information than a plain film x-ray. It is also noted in Dr. 07/06/11 note that an MRI cannot be obtained due to the presence of a metallic screw; however, it is not clear based on the documentation the location of the screw or if it would in fact create artifact or inhibit the evaluation of the foot and ankle on the CT scan. Furthermore, the operative report from Dr. dated 05/04/09 was an extensive arthroscopic debridement with chondroplasty, so it is unclear how or why the claimant has a metallic screw. Furthermore, when one references the ODG 2011 edition, Ankle and Foot Chapter, The American College of Radiology (ACR) Appropriateness Criteria for Chronic Ankle Pain does not highly rate a CT scan as the appropriate choice to evaluate instability or osteochondral defects. Therefore, the requested repeat CT scan of the left ankle is neither reasonable nor necessary and the previous adverse determinations should be upheld.

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)