

# US Resolutions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/11/2011

**IRO CASE #:**

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

MRI LT ankle with and with contrast

**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**

ODG Ankle and Foot/ MRI

Peer Review 04/18/11, 05/09/11, 05/13/11

Emergency Department Record 06/09/09

Dr. OV 04/06/10, 05/14/10, 05/23/10, 06/11/10 , 08/12/10, 09/29/10 , 10/27/10 , 12/30/10., 03/14/11

Dr. OV 08/16/10, 10/11/10

Dr OV 04/32/10, 05/07/10

MRI left ankle 05/21/10

EMG 06/01/10

X-ray left foot 06/09/09

MRI left brachial plexus 10/01/10

CT thoracic spine 06/09/09

Computerized Muscle Testing 06/29/10

Request form 05/14/11

**PATIENT CLINICAL HISTORY SUMMARY**

This is a patient who reportedly sustained multiple injuries as a result of a work related injury on xx/xx/xx. Diagnoses included left ankle sprain/ strain and left ankle internal derangement along with cervical / thoracic radiculitis, lumbar radiculopathy, left shoulder impingement and obesity. A left foot x-ray dated 06/09/09 showed a compressed calcaneal fracture.

Chiropractic records of 2010 revealed the claimant with continued left ankle pain. Review of a left ankle CT of an unknown date did reveal some fibrocartilage deformity changes. A left ankle MRI performed on 05/21/10 showed minimal effusion of the tibiotalar joint, narrowing of the subtalar joint, hypertrophic bony changes at the dorsal talonavicular joint, previous transchondral injury with secondary bone edema and sprain/ tear at the anterior talofibular ligament. The claimant continued under chiropractic care with diagnosis of left ankle sprain/ strain. A left ankle MRI was recommended.

A podiatry examination of 08/16/10 noted the claimant with pain at the sinus tarsi left foot with limited range of motion. A follow up physician record dated 10/11/10 noted the claimant with continue left foot pain with pain at the sinus tarsi. X-rays showed a chip fracture to the lateral navicular bone. A non-union navicular left was diagnosed.

A chiropractic physician record of 03/14/11 revealed the claimant with continued left ankle pain with a left ankle MRI denied. Moderate left ankle swelling and pain with palpation was noted on examination along with a positive anterior posterior drawer for laxity and pain of the left ankle. Left ankle internal derangement was diagnosed. According to the treating physician, a left ankle MRI would be medically necessary as a chondral fracture had not been ruled out as a source of pain and swelling.

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

In this case given the tear of the ATFL and the MRI of 05/21/10 the reported chipped lateral navicular fracture per Dr. of 10/11/10 with persistent reports of pain and swelling of the ankle and positive anterior draws sign documented by Dr. MRI with and without contrast is medically necessary to evaluate for chronic ankle pain with suspected osteochondral injury and ligament injury, instability, pain and swelling since the injury. The provider will then be able to correlate this with the MRI of the left ankle from 05/21/10. Based on review of the records provided and the evidence based medicine, the reviewer finds that there is medical necessity for MRI LT ankle with and with contrast.

**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)