

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Dec/03/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI Left Ankle

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

Board Certified Orthopedic Surgeon (Joint)

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 medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

X-ray of the left foot dated 08/30/13

MRI of the left ankle dated 09/09/13

Clinical note dated 09/17/13

Clinical note dated 10/29/13

Clinical note dated 11/19/13

Adverse determinations dated 10/31/13 & 11/15/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury regarding his left ankle and foot. The x-rays of the left foot dated 08/30/13 revealed osteoarthritis at the 1st MP joint. Plantar calcaneal and retrocalcaneal spurs were noted. The MRI of the left ankle dated 09/09/13 revealed an osteochondral lesion of the medial talar dome, the navicular tarsal bone, and the 1st and 2nd cuneiform bones without cartilage defects. The clinical note dated 09/17/13 indicates the patient complaining of left foot pain. The note indicates the patient stating the initial injury occurred when he was getting off a truck and twisted his left foot. Swelling was noted at the left lower extremity. Tenderness was noted upon palpation. The note indicates the patient utilizing a cam boot as well as Naproxen. The clinical note dated 10/29/13 indicates the patient continuing with left foot pain and swelling. The patient rated the pain as 8/10 at that time. The clinical note dated 11/19/13 indicates the patient continuing with tenderness at the left ankle. The patient was able to demonstrate 5-/5 strength with left ankle eversion.

The utilization review dated 10/31/13 resulted in a denial for a repeat MRI of the left ankle as no information was submitted confirming the patient's significant changes in the symptomology.

The utilization review dated 11/15/13 resulted in a denial for a repeat MRI of the left ankle as no progressive findings were noted with the patient's clinical presentation.

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

The documentation submitted for review elaborates the patient complaining of left ankle pain with associated tenderness. A repeat MRI of the ankle would be indicated provided the patient meets specific criteria to include significant changes noted with the patient's symptomology or significant pathology noted by exam. No information was submitted regarding the patient's progressive nature of the ongoing complaints of left ankle pain. Given this, it does not appear that a repeat MRI would be medically necessary for this patient at this time. As such, it is the opinion of this reviewer that the request for a repeat MRI of the left ankle is not recommended as medically necessary.

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)