



Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 03/05/13

IRO CASE #:

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

Texas-licensed M.D., board certified in Orthopedic Surgery

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of the right foot.

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)

Primary Diagnosis Code	Service Being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim #	Upheld Overturn
825.24			Prosp.				11/11/12		Upheld
825.5	73718		Prosp				11/11/12		Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a xx-year-old male who fell from a height, suffering left foot fracture and multiple fracture of the right foot. He was seen at the emergency room where a CT scan of the right foot included diagnoses that were provided of cuneiform fracture, cuboid fracture, and metatarsal fractures. The patient received a recommendation for surgical procedure. It is not clear whether that surgical procedure was performed. He received physical therapy on a number of occasions between XXXX and XXXX. He has had persistent swelling and pain in the right midfoot. Interpretation of plain x-rays is not provided. A request for MRI scan of the right foot has been submitted. It was considered and denied; it was reconsidered and denied.

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

The medical records provide little indication for MRI scan of the right foot. Plain x-rays are not provided. The formal interpretation of the CT scan of the right foot is not provided. History does not include full elements of treatment including the possibility that a surgical procedure was performed. In the absence of a complete history and physical examination, the request for MRI scan right foot cannot be approved.

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 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-Office 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)