



Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 10/21/13

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:

Removal of hardware; arthroscopy, ankle; extensive debridement.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld** (Agree)
 Overtured (Disagree)
 Partially Overtured (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
996.78	29898		Prosp.				Xx/xx/xx		Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- TDI case assignment.
- Letter of denial 09/08/13 & 10/01/13, including criteria used in the denial.
- Treating doctor's office visits on 08/16/13 & 09/13/13.

PATIENT CLINICAL HISTORY (SUMMARY):

The claimant is a female custodian who suffered a right ankle fracture on xx/xx/xx. She was treated with open reduction and internal fixation. She has had persistent pain, tenderness, and swelling in the region of the right ankle in spite of physical therapy, activity modifications, ambulatory support utilizing a cane, and medications. The current request is for pre-authorization of an arthroscopic surgical procedure for extensive debridement of the right ankle joint and removal of the internal fixation hardware. The request for surgical pre-authorization has been 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 specific source of the pain or sources of the claimant's right ankle pain has not been determined. There is no documentation of efforts to relieve the claimant's ankle pain utilizing local injection or intermittent ankle support or immobilization. The type of internal fixation hardware present has not been documented and the location of the claimant's pain specific in reference to the internal fixation hardware has not been documented.

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)