

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jan/02/2014

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: M.D., Board Certified Orthopedic 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 medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that a repeat MRI of the left ankle is not indicated as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical note dated 01/31/12
X-rays of the left ankle dated 01/16/12
X-rays of the left foot dated 01/25/12
MRI of the left ankle dated 03/29/12
Clinical note dated 03/27/12
Clinical note dated 04/10/12
Clinical note dated 04/24/12
Clinical note dated 05/08/12
Clinical note dated 06/12/12
Operative report dated 07/09/12
Therapy note dated 07/24/12
Therapy note dated 09/12/12
Therapy note dated 09/17/12
Clinical note dated 11/08/13
Adverse determinations dated 11/13/13 & 12/04/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his left ankle. The clinical note dated 01/31/12 indicates the patient complaining of left ankle pain when he sustained a crush injury on xx/xx/xx. The note mentions the patient utilizing Norco and Ultram for pain relief. The patient did report slight improvements with his pain level. The MRI of the left ankle dated 03/29/12 revealed a medial talar dome edema adjacent to the medial talar cortex extending inferiorly. Posterior tibial tenosynovitis was also noted. The operative report dated 07/09/12 indicates the patient undergoing an arthroscopic debridement with a partial synovectomy and treatment of the talar dome osteochondral lesion. The therapy note dated 09/17/12 mentions the patient having completed 15 physical therapy visits to date. The clinical note dated 11/08/13 mentions the patient presenting with

severe pain at the ankle. The pain was located at the anterior aspect of the ankle. The patient also reported an increasing pain by the end of each day. No locking or popping was noted. The note does mention the patient being a current every day smoker of approximately 1 pack per day. The patient is noted to ambulate with a normal gait. No signs of infection were noted. Tenderness was noted at the anterior aspect of the ankle. Good range of motion was noted throughout the ankle. No ligamentous laxity was noted.

The utilization review dated 11/13/13 resulted in a denial as no plain radiographs were submitted. No therapeutic interventions were noted.

The utilization review dated 12/04/13 resulted in a denial for a repeat MRI of the left ankle as no significant findings were noted by physical examination.

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 despite a previous surgical intervention. An MRI of the left ankle would be indicated provided the patient meets specific criteria to include significant functional deficits noted at the left ankle. No objective data was submitted confirming any functional deficits at the left ankle. No information was submitted regarding the patient having undergone a recent course of physical therapy addressing the left ankle complaints. As such, it is the opinion of this reviewer that a repeat MRI of the left ankle is not indicated 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)