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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/21/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: arthroscopy left ankle, debridement, modified brostrum, ORIF of non union with proximal tibial bone graft

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 the request for an arthroscopy at the left ankle, debridement, and modified Brostrum, is not recommended as medically necessary; however, the requested ORIF of the nonunion with proximal tibial bone graft is medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who presented with left ankle and foot pain. The patient reported falling twisting his ankle. The date of injury is xx/xx/xx. The clinical note dated 08/21/13 mentions the patient having presented to the emergency room where x-rays were obtained. The patient was diagnosed with an ankle fracture. The patient was provided with a splint and crutches. The patient described the pain as a sharp, aching, and cramping sensation that he rated as 9/10. The note mentions the patient utilizing a walking boot. Upon exam, no strength deficits were identified. The patient ambulated with an antalgic gait. Mild swelling was noted throughout the left foot. Positive talar tilt and anterior drawer exams were identified. The patient was able to demonstrate essentially full range of motion throughout the ankle. X-rays of the left foot ankle revealed a lateral malleolus fracture. The ankle mortis appeared well-maintained. The clinical note dated 01/29/14 mentions the patient utilizing a bone growth stimulator for the previous 3 months. The patient continued with persistent pain. Mild tenderness upon palpation was identified over the fracture site. 2+ instability to drawer testing was revealed. No range of motion restrictions were identified. Updated x-rays revealed no evidence of healing at the fracture site. The patient was recommended for an ORIF at the fracture site along with a lateral ligament reconstruction.

The utilization review dated 02/18/14 resulted in a denial as inadequate information was provided at that time confirming the need for the requested Brostrum procedure.

The utilization review dated 03/04/14 resulted in a denial as no imaging studies were submitted confirming a ligament tear that would reasonably require a ligament reconstruction.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient having complaints of left ankle pain. An ORIF and modified Brostrum would be indicated provided the patient meets specific criteria to include imaging studies confirming the patient's displaced fracture as well as a tear of the lateral ligament. The submitted x-rays do reveal significant findings and therefore, the patient may benefit from an ORIF. However, no imaging studies were submitted confirming the need for a lateral ligament reconstruction/Brostrum procedure. The submitted radiographs revealed no significant motion at the ankle or subtalar joint. Given these findings, the requested ORIF is indicated as medically necessary. As such, it is the opinion of this reviewer that the request for an arthroscopy at the left ankle, debridement, and modified Brostrum, is not recommended as medically necessary; however, the requested ORIF of the nonunion with proximal tibial bone graft is medically necessary. This request is partially overturned.

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)