

Notice of Independent Review Decision

February 25, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Medical Necessity CT Scan Left Hind Foot

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. The physician has been in practice since 1982 and is licensed in Texas and Oklahoma.

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 of the health care services in dispute.

Upon independent review, I find the previous adverse determination should be Upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records Received: 18 page fax 2/05/14 Department of Insurance IRO request, 26 pages received via fax 2/10/14 URA response to disputed services including administrative and medical. 4 pages received 2/14/14 Provider response to disputed services including administrative and medical. Dates of documents range from xx/xx/xx (DOI) to 2/05/14.

PATIENT CLINICAL HISTORY [SUMMARY]:

This male sustained a fracture of the left calcaneus when he fell xx/xx/xx. Subsequently, x-rays have documented a healed calcaneal fracture.

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On 01/07/14, noted the patient had not had physical therapy and the pain in the heel was worse. The physical examination noted an antalgic gait, walking on the toes to avoid the heel. Some widening of the heel with a mild varus was identified with medial and plantar heel region tenderness. Sinus tarsi tenderness was also noted. Ankle motion was full without pain. Some restricted subtalar motion with pain was noted. A new CT scan to evaluate for posttraumatic arthritis of the subtalar joint was requested.

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

The rationale for upholding the previous recommendations for an adverse decision is that the medical records did not document a condition for which *ODG* would recommend a CT scan of the left foot and ankle and did not contain the results of an MRI scan recently performed. The determination is from *ODG* foot and ankle chapter on CT scan, which does indicate a CT scan to evaluate for masses and for an undetermined fracture, which is not noted on plain film imaging.

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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 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)