

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0820-01

IRO Certificate No.: 5259

February 19, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in family practice. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by \_\_\_\_, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

\_\_\_ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to \_\_\_.

### CLINICAL HISTORY

This patient sustained a Grade I (mild) ankle sprain on \_\_\_\_. She received extensive care including work restrictions, a splint, crutches, medications, and physical therapy. She had plain radiographs, an MRI, a bore scan, an electro-diagnostic testing done to evaluate her injury on 7/25/03, an MMI report documents an impairment rating of 5%.

### REQUESTED SERVICE (S)

Intra-articulate joint injection.

### DECISION

Uphold prior denial.

### RATIONALE/BASIS FOR DECISION

This patient has undergone exhaustive diagnostic testing and treatment for a minor soft tissue injury. An excellent designated doctor's exam was done on 9/25/03, and there is concurrence with \_\_\_ conclusion that this patient is, unfortunately, a chronic pain patient at this point. She has reached MMI\* and no generally accepted guidelines nor literature support the use of intra-articular injections in a patient with chronic ankle pain. Therefore, the prior denial is upheld.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
Texas Workers' Compensation Commission  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 19<sup>th</sup> day of February 2004.