# Becket Systems
**An Independent Review Organization**
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## *Review Outcome*

### *Description of the service or services in dispute:*
XX arthroscopy and XX XX nerve XX

XX: Arthroscopy, ankle (XX), surgical; XX, extensive

XX: Arthroscopy, ankle (XX), surgical; XX, partial

XX: XX, major XX, arm or leg, open; other than specified

### *Description of the qualifications for each physician or other health care provider who reviewed the decision:*
Board Certified Orthopedic Surgeon

### *Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:*
☐ Overturned (Disagree)

☑ Upheld (Agree)

☐ Partially Overturned (Agree in part / Disagree in part)

### *Patient Clinical History (Summary)*
XX is a XX-year-old XX who sustained a XX ankle injury at work on XX. XX was diagnosed with XX, XX XX limb (XX); XX and XX, unspecified (XX); and sprain of unspecified ligament of XX ankle, initial encounter (XX).

On XX XX was evaluated by XX, XX for follow-up on XX XX ankle injury. XX continued to complain of pain around the ankle as well as burning pain that radiated down the XX of the foot. XX received a few days of pain relief from intra-articular steroid injection performed on XX, but the pain had returned. XX took XX for the pain and had been working with restrictions. XX was extremely frustrated at that point. On examination, XX ambulated on XX XX extremity with an XX. The XX ankle had some diffuse tenderness. There was positive XX sign at the XX. Dr. XX noted XX was clearly not responding to nonoperative management and recommended a XX ankle arthroscopic examination for treatment of XX as needed for XX persistent pain as well as a superficial peroneal nerve neurolysis.

An x-ray of the XX ankle dated XX was nonsignificant for any acute abnormalities of the ankle.

An MRI of the XX ankle dated XX and an addendum dated XX, revealed XX. The XX were intact. Mild XX signal was seen adjacent to the common XX, consistent with XX. XX, XX, and XX were intact.

Treatment to date included medications (XX), intra-XX steroid injections (pain relieved for few days) and work restrictions.

Per a utilization review determination letter by XX dated XX, the request for XX ankle arthroscopy (XX) was noncertified. It was determined that the guidelines stated that there was insufficient evidence to support or refute benefits of arthroscopy for XX. Also, there was insufficient objective evidence of failure from conservative therapy before considering the XX intervention.

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# *Notice of Independent Review Decision*

Case Number: XX Date of Notice: 01/02/19

A letter from XX dated XX indicated that the reconsideration request for XX ankle arthroscopy (XX) was denied as it did not meet medical necessity guidelines. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced - However, the indication for arthroscopy is unclear. In addition, there was insufficient objective evidence of failure from conservative therapy such as PT/HEP before considering the surgical intervention. I made multiple attempts to contact the surgeon to garner additional information or exceptional circumstances. This was unsuccessful. Therefore, based upon the provided documentation, the request is not currently supported."

***Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.***

In review of the provided records, there is evidence of chronic pathology at the XX ankle on MRI and radiographs. The claimant's physical exam findings noted an XX gait with some tenderness to palpation. No significant deficits were noted on the claimant's physical exam findings. At this point, it is still unclear how further surgery would reasonably improve the claimant's functional abilities as related to the work injury. Therefore, it is this reviewer's opinion that medical necessity is not established.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation
- ☐ Policies and 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-Official Disability Guidelines and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

**Appeal Information**

## *Notice of Independent Review Decision*

Case Number: XX Date of Notice: 01/02/19

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.