**Becket Systems**
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# *Notice of Independent Review Decision*

**IRO REVIEWER REPORT**
**Date:** X
**IRO CASE #:** X

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** X

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

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned (Disagree)

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

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:** • X

**PATIENT CLINICAL HISTORY [SUMMARY]:** X who was injured on X. The biomechanics of the injury was not included in the provided records. The diagnosis included sprain of calcanofibular ligament of left ankle, sprain of tibiofibular ligament of left ankle and disorder of ligament of left ankle.

On X, X was seen by X, MD for reevaluation of X persistent osteochondral lesion of the medial talar shoulder. X was status X. Since X was last seen, X had to get back into X walking boot for about  days due to worsening symptoms. Since then, X had been able to wean out of X boot but continued to note left anteromedial ankle pain with prolonged weightbearing activities. X wanted to discuss other surgical options. Examination of ankle showed X. Slight swelling was noted of the left X. Persistent tenderness was noted over the X. X had near X. X was recommended.

An MRI of the left ankle dated X showed X. X. The graft itself was indistinct, but there was no fluid filled gap. X within the X was noted. There was X. If warranted a X. X was noted. There was X.

Treatment to date included X.

Per a Peer Review Report dated X by X, MD, the request for X, X was noncertified. Rationale: “ODG X. Not recommended for X. ODG Criteria ODG Indications for Surgery - Arthroscopy of ankle and foot: Not recommended for treatment of X. - X. Osteochondral resurfacing procedures may be a salvage option, particularly in athletes, following failure of both non-operative treatment and microfracture of the talus: only with normal ankle motion, closed growth plates, and absence of tibial lesions." The records did not detail the X. The post-operative

imaging report did not detail specific pathology to warrant additional surgery. No significant functional loss was evident at the current evaluation. Given these issues, which do not meet guideline recommendations, this reviewer cannot recommend certification for the request. Therefore, the request for X is non-certified."

Per another Peer Review Report dated X by X, MD, the request for X was not medically necessary. Rationale: "The worker had prior surgery in X and has new symptoms. The exam and MRI findings are nonspecific and there is no documentation of recent non-surgical treatment such as X. Therefore, the request for Appeal - X is not medically necessary."

Based on the submitted medical records, the imaging report does not support the requested X. In addition, there is no documentation provided to demonstrate that the claimant has undergone appropriate conservative treatment including X. As such, no new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified.

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

Based on the submitted medical records, the imaging report does not support the requested surgical procedure as there was no definitive osteochondral defect. In addition, there is no documentation provided to demonstrate that the claimant has undergone appropriate X. As such, no new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified.

**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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**