

Notice of Independent Review Decision
Amended and sent on X

SENT TO: Texas Department of Insurance
Managed Care Quality Assurance Office
(MCQA) MC 103-5A
E-mail IRODecisions@tdi.state.tx.us

DATE OF REVIEW: X
Date of Amended Decision: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:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X with reported date of injury of X. X apparently twisted X left ankle X. X is diagnosed with pain in the left ankle, loose body in left ankle, and peroneal tendon strain. MRI dated X demonstrated a X. X has persistent left ankle pain and functional disability. Exam demonstrates tenderness in the anterolateral ankle and over the peroneal tendons. X has been treated with X. At this point the request is for an X to the left ankle.

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

Per ODG references the requested: " X" are medically necessary for the patient.

While the ODG do not recommend X for the foot and ankle there is a carve out for an indication for doing a X. This patient has undergone long term conservative treatments for X ankle injury and

continues to have unresolved symptoms. In this case, given the failure of other conservative treatments, I do think that a X should be approved using the guidelines of X.

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 KNOWLEDGE BASE
- 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

- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED
MEDICAL LITERATURE (PROVIDE A
DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY
VALID, OUTCOME FOCUSED GUIDELINES