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Notice of Independent Review Decision
Amendment X

IRO REVIEWER REPORT

Date: X; Amendment 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 Overturned (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 is a X who was injured on X. The diagnosis was X osteochondritis dissecans, right ankle and joints of right foot; X sprain of other ligament of right ankle, initial encounter; X nondisplaced other extraarticular fracture of right calcaneus, initial encounter for closed fracture. X, MD saw X on X for a follow-up evaluation for lateral right ankle pain. X described the symptoms as aching, stabbing, and throbbing. Since the onset, X reported the problem was unchanged. X experienced clicking, nighttime discomfort, popping, locking, and snapping. Symptom onset was X after inverting X right ankle while at work. X was evaluated at X where a sprain was diagnosed, and X was provided with a brace. X went back to work on X where after walking for extended periods, X felt a pop on the anterolateral aspect of X ankle and noticed immediate sharp pain, which radiated to X knee. X reported that X went back to X where an X was ordered. X was completed on X. X reported that X had gone to X. X reported X week ago, X went back to X where a boot was provided. X reported that symptoms improved with wearing the boot. X stated X experienced painful popping sensations with circumduction of X ankle. Examination of the right ankle / foot noted swelling of the hindfoot and plantar surface of the foot; moderate tenderness on all sides of the hindfoot to light and deep palpation, and ecchymosis noted in the hindfoot and plantar surface of the foot. Tendon function

of the foot and ankle was intact, with pain reproduced mainly with plantarflexion. X-rays of the right ankle were obtained and showed what appeared to be more callus in the anterior process of the calcaneus without displacement. The assessment was X osteochondritis dissecans, right ankle and joints of right foot; X sprain of other ligament of right ankle, initial encounter; X nondisplaced other extraarticular fracture of right calcaneus, initial encounter for closed fracture. Dr. X assessed that X was with instability after inversion injury X months out status post conservative treatment with continued pain, popping, and weakness. MRI demonstrated a X. X had partial deltoid sprain as well. The calcaneus fracture usually would heal on its own and show signs of it on the x-ray obtained that day. It usually did not have to be addressed surgically. But the continued pain, popping, and locking and instability came from X OCD lesion and ATFL rupture. The surgical approach was discussed that would include X. X-rays of the right ankle dated X showed what appeared to be X. An MRI of the right ankle dated X identified X. There was X. There was X. There were also X. A X was noted, compatible with X. X was seen. X was seen with X. X were noted. There was X noted. Treatment to date included X. Per a utilization review dated X, X did not agree that X work-related injury caused some of X medical conditions (extent of injury. Rationale: "X, is disputing entitlement of benefits for the conditions/diagnoses as noted in the X right ankle X. The compensable injury of X is limited to right ankle sprain, osteochondral lesion with associated microtrabecular fracture and bone bruises. Per the X peer review of Dr. X, there is no medical documentation to justify a causal

connection between the above-listed conditions and the accepted work injury and no aggravation or exacerbation of the above listed conditions. "Per a utilization review adverse determination letter dated X, and a peer review dated X, the request for X was denied by X, MD. Rationale: "The request is not medically necessary. Based on the provided documentation, the claimant has right ankle pain. The physical examination of the right ankle noted X. Tenderness with palpation pain with range of motion. Per ODG guidelines, "Conditionally recommended for X." While the claimant has right ankle pain, there is no formal imaging report provided for review. The claimant will need an updated imaging report. Therefore, X is not medically necessary. "Per a reconsideration review adverse determination letter dated X, the appeal request for X, performed at X was denied. The prior denial was upheld by X, MD. Rationale: "The request is not medically necessary. The ODG notes that X is not recommended for treatment of X. X is recommended for X. Considering that the claimant has X would be medically necessary. The ODG notes that X is not recommended, as there are no quality peer reviewed studies. Therefore, the possible X is not medically necessary. In regard to the X, the ODG notes that X may be indicated when all of the following are met: X. X of X. Persistent ankle instability on manual stress examination (ie, positive anterior drawer and/or talar tilt test), or documentation on magnetic resonance imaging of injury that is appropriate for surgical intervention." On review of the records the claimant has tried bracing. Review of clinical exam findings from X & X and diagnostics do not identify grade III lateral ligamentous rupture

and/or syndesmotic ankle sprain. There is also no documentation that the claimant has X. There have been X or X. There has been less than X months of treatment from date of injury in X and reinjury in X. As of X, the physical therapist had noted that the claimant was "getting better." On physical exam from X there was noted to be tenderness, swelling and ecchymosis to the hindfoot and plantar surface of the foot. There was no documentation of instability on exam. In fact, the progress notes from X stated that there was no instability. These findings on recent exams would not be consistent with A TFL rupture warranting surgical intervention. More so, the deltoid ligament appears to be more involved on MRI than the A TFL. Therefore, the X is not medically necessary. In summary, the Appeal-X is medically necessary though the X is not medically necessary. However, as this is a Texas case and I was unable to reach the treating physician to discuss treatment modification, the request remains not certified at this time. Therefore, the request for X is not medically necessary. "The requested X is not medically necessary. The submitted records do not demonstrate an appropriate course of conservative treatment rendered. There are insufficient examination findings to support the X. The guidelines do not recommend the use of X. No new records have 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:

The requested X is not medically necessary. The submitted records do not demonstrate an appropriate course of conservative treatment rendered. There are insufficient examination findings to support the X. The guidelines do not recommend the use of X given insufficient medical literature. No new records have been provided which would overturn the previous denials. X is not medically necessary and non-certified.
Upheld

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)