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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 Overturned Agree in part/Disagree in part

☐ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X had a work-related injury where a X. The diagnosis was arthralgia of the left ankle and / or foot and closed fracture dislocation of tarsometatarsal (TMT) joint. On X, X, MD evaluated X for left foot / ankle work injury. X had pain in all the toes, ball of X foot and ankle. X stated a X. X was no weightbearing in a walking boot and crutches. X was going to physical therapy, but stated it made the pain worse. On examination, dorsalis pedis and posterior tibial pulses were palpable. X gait was non-antalgic. Sensation was intact to light touch at superficial peroneal, deep peroneal, saphenous, sural, and tibial nerve distributions. Vibratory sensation was intact but decreased over the left deep peroneal and superficial peroneal nerve distributions. Left lower extremity examination revealed limited range of motion of the ankle and foot and toes secondary to pain but intact. There was tenderness to palpation over the left first and second tarsometatarsal joints. Right lower extremity examination revealed positive double heel and single heel rise. On X, X, PA-C evaluated X follow-up of left foot X injury. X was X months and X weeks post work injury. X was recently at the emergency room for severe left foot pain. X-rays were taken in the clinic. X stated having arch pain. X had no new trauma to the foot and X was taking X for the pain. On examination, dorsalis pedis and posterior tibial pulses were palpable. X gait was non-antalgic. Sensation was intact to light touch at superficial peroneal, deep peroneal, saphenous, sural, and tibial nerve distributions. Vibratory sensation was intact but decreased over the left deep peroneal and superficial peroneal nerve distributions. Left lower extremity examination revealed limited range of motion of the ankle and foot and toes secondary to pain but intact. There was tenderness to palpation over the left first and second tarsometatarsal joints. Right lower extremity examination revealed positive double heel and single heel rise. Per the assessment, X had a X pound X on X left foot while at work overlying X left first and second TMT joints on X for which X continued to have pain and could not walk outside the boot. X reported that the pain had

significantly increased from a X to a X. X had been seen at the emergency room secondary to this. X recent surgery was denied and X still could not ambulate without the boot because the pain in between X Lisfranc joint. Unfortunately there were two components to X injury. X did have pain in a deep peroneal and superficial peroneal nerve distributions that most likely would take time to resolve. Unfortunately what was most troubling was that X could not get out of the boot without pain despite X months of non-operative treatment. At this time, X was refractory to non-operative course over the past X months consisting of X. X could not walk outside the boot. As per Dr. X at this time X most likely had a Lisfranc injury and the recommendation was surgical intervention in the form of left first and second TMT arthrodesis (X). X would not need preoperative medical clearance and Dr. X would set X up for outpatient surgical intervention and again per Dr. X no certified surgical first assist would be utilized. X was cautioned that there may not be anything Dr. X could do for the nerve damage that X may have sustained. Dr. X would perform this without a nerve block and only do local administration for pain control. X would remain on sedentary duty, could sit for X hours, no standing, no ambulating. An MRI of left forefoot dated X revealed unremarkable noncontrast MRI of left foot. An MRI of left hindfoot dated X revealed subacute-chronic sprain of the calcaneofibular ligament and mild tendinosis of the peroneus longus, along the undersurface of the calcaneocuboid joint. Treatment to date included medications X . Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “The Official Disability Guidelines support a fusion procedure after a Lisfranc injury. This claimant has continued left sided toot pain and there was an inability to walk without a walking boot. There are findings consistent with a Lisfranc injury on radiographs and MRI of the left foot. Considering these symptoms, and objective findings, this request for a X would be supported. Postoperative use of a X will also be needed in the postoperative period for protection and irnmobilization. Accordingly, the request for a X is also supported. However, guidelines only support A X . As this is a routine fusion procedure, the request for a X is not supported. However, as no peer was established, this request is not certified in its entirety.”Per a reconsideration / utilization review adverse determination letter dated X, by X, DO, the request for X was denied. Rationale: “Official Disability Guidelines recommends Arthrodesis for foot fractures On X, the claimant complaints of continued left-sided ankle and foot pain; unable to

ambulate outside of a walking boot. Left lower extremity exam shows limited range of motion of the ankle, foot, and toes secondary to pain; tenderness over the X. Surgery is supported due to failure of conservative treatment and positive objective and imaging findings; however, the requested X is non-certified. A partial recommendation could not be rendered. As such, the request for X is non-certified. Official Disability Guidelines recommends surgical assistant for complex surgeries. On X, the claimant complaints of continued left-sided ankle and foot pain; unable to ambulate outside of a walking boot. Left lower extremity exam shows limited range of motion of the ankle, foot, and toes secondary to pain; tenderness over the X. There are no indications that the requested surgery is or will be complicated. As such, the request for X is non-certified. Official Disability Guidelines recommends postoperative use of X. On X, the claimant complains of continued left-sided ankle and foot pain, unable to ambulate outside of a walking boot. Left lower extremity exam shows limited range of motion of the ankle, foot, and toes secondary to pain; tenderness over the X. Although, the request is supported, the requested X is non-certified. A partial recommendation could not be rendered. As such, the request for X is non-certified."Per a reconsideration / utilization review adverse determination letter dated X, by X, DO, the request for X was denied. Rationale: "Official Disability Guidelines recommends arthrodesis for foot fractures On X, the claimant with continued left-sided ankle and foot pain. Exam shows limited ankle, foot toes range of motion due to pain; tenderness to palpation over the X. Surgery is supported due to failure of conservative treatment and positive objective and imaging findings; however, the requested X is non-certified. A partial recommendation could not be rendered. As such, the request for X is non-certified. Official Disability Guidelines recommends surgical assistant for complex surgeries. On X, the claimant with continued left-sided ankle and foot pain. Exam shows limited ankle, foot toes range of motion due to pain; tenderness to palpation over the X. There are no indications that the requested X is or will be complicated. As such, the request for X is non-certified. Official Disability Guidelines recommends postoperative use of X. On X, the claimant with continued left-sided ankle and foot pain. Exam shows limited ankle, foot toes range of motion due to pain; tenderness to palpation over the X. Although the request is supported, the requested X is non-certified. As partial recommendation could not be rendered. As such, the request for X is non-certified. The requested X is medically necessary and has met the appropriate

guidelines. Per the medical record from the treating provider on X, the provider will not use a X for the procedure. The guidelines do not support a X for this procedure. Given this information, the surgical request is modified to exclude the X from the X procedure. As the X procedure is medically necessary, the X is supported. Requested Services: X , is medically necessary and partially overturned X and indicated procedure is medically necessary and certified , the X is not medically necessary and non certified. X is medically necessary and certified

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

The requested X procedure is medically necessary and has met the appropriate guidelines. Per the medical record from the treating provider on X, the provider will not use a X for the procedure. The guidelines do not support a X for this procedure. Given this information, the X request is modified to exclude the X. As the X procedure is medically necessary, the X is supported. Requested Services X and indicated procedure X, is medically necessary and partially overturned X and indicated procedure is medically necessary and certified, the X is not medically necessary and non certified. X is medically necessary and certified

Partially Overturned

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

☐ 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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL