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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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X was leaving the X. X missed a X. The diagnosis included sprain of foot, closed fracture of metatarsal bone, metatarsal bone fracture and closed fracture of third metatarsal bone. On X, X was seen by X, MD for X. X reported doing very well having nearly completed X. There was some X. X was ready to return to work without restriction. Examination showed X X. Evaluation of the right foot revealed the surgical scar over the dorsal aspect of the midfoot was well-healed. There were no signs of infection, erythema, or drainage. There was mild residual swelling. There was active dorsiflexion, plantar flexion, inversion, and eversion. X of the X. There was a X. There was X. X was doing very well approximately X months following surgery. X was recommended removal of the X. This was performed in order to X. Postoperative, X would be X. However, X would be expected typically on X. X presented to X, PT on X for X. X had a follow up with Dr. X and was scheduled to have X. X stated X right foot was much improved, but felt X. Examination showed X. Minimum edema was noted on the right, effusion figure X cm and ankle girth measurement malleolar level X cm, mid foot X cm. Right ankle showed well healed incision to dorsum of right foot, X cm left and small incision over medial cuneiform displayed mild scabbing. Right ankle showed tenderness over incisions. Great toe extension to “X degrees” and flexion to “X degrees”. Strength in gastrocnemius X, toe flexion X and extension X Physical therapy was done. X could be discharged from physical therapy to continue with X home exercise program but that after X. CT scan of the right lower extremity dated X revealed X. X was noted based with X of the medial and lateral cuneiforms as well as of the cuboid. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Based on the documentation provided, the claimant is X months status post X. According to the ODG, Ankle and Foot online chapter, X is not recommended for X. Not recommended solely to protect against allergy, carcinogenesis, or metal detection. X is also not recommended following syndesmosis repair or to prevent metal detection at airports. X is appropriate for some situations where fractures may not be involved. Pins stabilizing a joint following ligament or tendon repair must eventually be removed so that the joint can resume function (eg1 pin across a joint to stabilize an extensor tendon repair1 or temporary joint stabilization following ligament reconstruction). In this case, the most recent office note by Dr. X dated X reported the claimant was doing very well having nearly completed physical therapy. There was some discomfort and mild residual swelling however, X was doing quite well having already transitioned

to regular shoes. Examination revealed the surgical scar over the dorsal aspect of the midfoot was well-healed. There were no signs of infection, erythema, or drainage. There was mild residual swelling. There was active dorsiflexion, plantar flexion, inversion, and eversion. Additionally, the X-rays of the right foot demonstrate a X. There is a X. There is X. The treating provider reported the X is performed in order to restore normal motion across the joint and to avoid hardware failure. However, guideline criteria have not been met. There is no evidence of exposed or prominent pins, broken hardware, or persistent pain. Therefore, medical necessity has not been established for the requested X. Per a utilization review adverse determination letter dated X by X, MD the request for X was not medically necessary. Rationale: “Official Disability Guidelines do not recommend X. On X, the patient was doing well approximately X months following surgery. X was recommended to X. On X, the patient reported doing well having nearly completed physical therapy. There was some discomfort and mild residual swelling. However, X was doing quite well having already transition to regular shoes. X was ready to return to work without restriction. A prior review dated X non-certified the request for X due to the guideline criteria was not met as there was no evidence of exposed or prominent pins, broken hardware, or persistent pain. In this case, the guidelines criteria were still not met. There was still no documentation of exposed or prominent pins, broken hardware, or persistent pain after ruling out other causes of pain. The claimant was noted to be doing well and was ready to return to work. As such, the medical necessity has not been established for reconsideration X.The requested X is not medically necessary as there is no documentation of X after ruling out other causes of pain. The claimant was noted to be doing well and was ready to return to work. No new information has been provided which would warrant the requested procedure and overturn the previous denials. The requested 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 as there is no documentation of X after ruling out other causes of pain. The claimant was noted to be doing well and was ready to return to work. No new information has been provided which would warrant the requested procedure and overturn the previous denials. The requested

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

☐ 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