I-Resolutions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 IR
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 790-2280
Email: @i-resolutions.com

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 mechanism of injury was described as a X. The diagnosis was bilateral ankle pain, bilateral foot pain, and right foot mass. On X, X, MD evaluated X for chief complaint of X. X was taking over-the-counter medications for pain. X had X. X had pain due to an X. The pain was located at the bilateral foot with pain intensity of X. The pain onset was gradual. The pain was aggravated by immobility. Right foot examination revealed X. On X, X, MD evaluated X for bilateral foot / ankle pain with pain level of X. X was taking over-the-counter medications for pain. X had X. X also complained of left knee pain. The pain was located at bilateral feet with pain intensity of X. The pain onset was gradual. X had bilateral ankle and left knee pain. On examination of right foot, there was X. Workers' Compensation denied X. An X was unable to be performed due to possible X. Surgical intervention was recommended to X. These changes were directly related to original X.X-rays dated X of the right ankle revealed X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: "The clinical basis for denying these services or treatment: Official Disability Guidelines conditionally recommends surgery for X. Guidelines indicate X. Progress note dated X indicated the claimant was seen X. Physical exam of left foot noted X. Records do not contain sufficient clinical documentation to support the request. Therefore, the request of X, is non-certified. "Per a reconsideration / utilization review adverse determination letter dated X, by X, DO, the request for X. Rationale: "Official Disability Guidelines conditionally recommends surgery for X. Guidelines indicate X. Progress note dated X indicated the claimant was seen for bilateral foot pain with a pain level of X. Physical exam of right foot noted X. Treatments have included X. While the claimant may benefit from the request, records do not indicate the X. Therefore, the request of X, is non-certified. The requested X of a right foot X is not medically necessary. No actual imaging reports have been submitted for review. In addition, it does not appear that the patient has X. No new information has been provided which would warrant the requested procedure and overturn the previous denials. The 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 of a right foot X is not medically necessary. No actual imaging reports have been submitted for review. In addition, it does not appear that the patient has X. No new information has been provided which would warrant the requested procedure and overturn the previous denials. The 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**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

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

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