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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

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. The mechanism of injury not available in the provided medical records. The diagnosis was pseudarthrosis after fusion or arthrodesis, other mechanical complication of other internal orthopedic devices; implants and grafts; subsequent encounter, hypertrophy of bone; right ankle and foot, acute osteomyelitis; right ankle and foot, lymphedema, tarsal tunnel syndrome; right, post-traumatic degenerative joint disease of right ankle and/or foot, traumatic arthropathy of the right ankle and/or foot, entrapment of plantar nerve, displaced bimalleolar fracture of right lower leg; sequel and overweight. On X, X was seen by X, MD, for a follow-up visit of right ankle pain. X described the pain as chronic. The quality was described as aching. X stated the aggravating factors were range of motion and weight-bearing. On examination, weight was 225 pounds and body mass index (BMI) was 30.51 kg/m2. Right ankle / foot examination revealed X. There was X present. There were no signs of infection seen. X was seen over the X. X was neurovascularly intact. There was X. X of the ankle showed X. X were X degrees. X test caused X. X exhibited normal X. An x-ray of the right ankle revealed X. There was healing X. The diagnoses were pseudarthrosis after fusion or arthrodesis; other mechanical complication of other internal orthopedic devices, implants and grafts, subsequent encounter; hypertrophy of bone, right ankle and foot; acute osteomyelitis, right ankle and foot; lymphedema; tarsal tunnel syndrome, right; posttraumatic degenerative joint disease of right ankle and / or foot; traumatic arthropathy of the right ankle and / or foot; entrapment of plantar nerve; displaced bimalleolar fracture of the right lower leg, sequela; and overweight. It was noted that X presented for follow-up of a X. There was probable healing of X. There

were no signs of active infection. X also had pain from X where the X. They discussed that it had been a X, and X was still not healed at the X. They did a X but the X. X stated X did okay if X was X. At that point, Dr. X recommended doing a X. At the same time, X would X the X, which would further X. The risks and benefits of X were discussed. X would continue to be off work. On X, X underwent X, by Dr. X. On X, X was seen by X, PA-C /X, MD, for a postoperative follow-up visit. X underwent X. The examination of operative site revealed the incision was clean and dry and healing well. There was no drainage. Range of motion (ROM) was acceptable at the postoperative visit. X was neurovascularly intact. An x-ray of the right foot revealed X. The diagnosis was pseudarthrosis after fusion or arthrodesis; other mechanical complication of other internal orthopedic devices, implants and grafts, subsequent encounter; and hypertrophy of bone, right ankle and foot. It was noted that X presented for X. X sutures were removed and Steri-Strips placed. The plan was to get X. X was to be no weightbearing for X weeks total and could start X in X weeks if X was comfortable. X was to continue off work. A prescription was written for X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “ODG by X. X is no longer recommended for X. Evidence Summary Several studies previously suggested that patients receiving X might have X. (1) (2) (3) (4) (EG 2) However, a more recent cohort study of X." The patient is a X who sustained an injury on X. The medical notes are confusing. The last surgical note is dated X. However, the recent medical note indicates this is a X. There is no documentation of a X. The request is not medically necessary and appropriate based on inadequate information provided to confirm a X. Therefore, the requested X is denied.” Per a reconsideration review adverse determination letter dated X by X, DO, the appeal request for X was denied. Rationale: The Official Disability Guidelines recommend X. On X, the claimant was seen for a postop visit. The

claimant is X. On examination, the X. There was X noted. There was X noted. The X was acceptable. X were removed and X placed. The plan is for X. The right foot x-ray noted X. This request was previously reviewed and denied as there is no documentation of a X, the diagnosis given is X. There is no documentation for delayed or X. Partial certification is not permitted in this jurisdiction without peer-to-peer discussion and agreement. As such, the request for X is noncertified. The requested X is not medically necessary. There is no documentation of a delayed X. As such, the guidelines have not been met. X as requested by X, M.D. with 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 X is not medically necessary. There is no documentation of a X. As such, the guidelines have not been met. X as requested by X, M.D. with X is not medically necessary and non certified
Upheld

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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)**