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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. At work, an equipment fell on X. X sustained fractures of X right third, fourth and fifth toes. The diagnoses were right hammer toe; closed fracture proximal phalanx, right toe; and acquired hallux valgus, right. X was seen by X, MD on X for a follow-up visit. X surgery was denied. On examination, X was X. X was intact to X. The right ankle range of motion (knee straight and knee bent) dorsiflexion was X degrees and plantar flexion was X degrees. Subtalar and transverse tarsal motion abduction was X degrees and adduction was X degrees. The right great toe range of motion dorsiflexion was X degrees and plantar flexion was X degrees. The right second toe range of motion dorsiflexion and plantar flexion was X degrees. Skin incisions were well-healed. There was mild swelling over the forefoot. There was hallux valgus deformity of the right great toe, hammertoe deformity of the right second toe, mild tenderness to palpation about the distal 3rd-5th phalanx, heels in X degrees of valgus, and evert on heel rise. X were X. The left ankle range of motion (knee straight) revealed dorsiflexion X degrees and plantar flexion X degrees. Subtalar and transverse tarsal motion abduction was X degrees and adduction was X degrees. The left great toe range of motion dorsiflexion was X degrees and plantar flexion was X degrees. Heels in X degrees of valgus and evert on heel rise. X were X. From the surgery, X was doing well. X had a crush injury to X right foot on X where X sustained fractures of X right third, fourth, and fifth toes. Unfortunately, because of the nerve damage that X sustained to X foot, X had a X and that created a X. The deformities that X had were directly related to the nerve damage that X sustained in X injury on

X. The deformities had continued to become worse and X continued to have cramping because of those deformities. X had already attempted X helped. X would be given another prescription for X. Worker's Compensation denied a request for X. X continued to have pain over X prior deformities secondary to X work injury. X third toe was actually becoming more deformed because X first and second had not been corrected. X had already attempted X. The deformities would continue to get worse unless the first and second toes were not corrected. X wore X. X had pain daily and that affected X work. It was noted that at that point, X would require X. Because the first and second toe deformities had not been corrected, X third toe deformity would also need to be corrected. It would be okay with a X. X would not need preoperative medical clearance and would be set for outpatient surgical intervention. X would continue on full duty at the time and X was prescribed X. X would be given an X. An X was prescribed for X as X was ambulatory, X had weakness or deformity of the foot and / or ankle, X required stabilization for medical reasons documented and in the diagnosis listed, and X had the potential to benefit functionality and assist in X. A CT of the right lower extremity without contrast dated X. Treatment to date included X. Per the Peer Review dated X by X, MD, the request for X was denied. Rationale: "The proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. Official Disability Guidelines conditionally recommends X. Official Disability Guidelines recommends X. Official Disability Guidelines conditionally recommends surgery for X. Progress note dated X indicated the claimant was seen X. Physical exam of right foot noted decreased sensation over forefoot with mild swelling, decreased range of motion in great toe, hallux valgus deformity of right great toe, hammertoe deformity of right second toe, mild tenderness on palpation of distal third through fifth phalanx, heels in X degrees of valgus with positive double and single heel rise. Records do not contain official imaging results to support the requested surgery. Therefore, the request of X, is

non-certified. "Per the Adverse Determination After Reconsideration Notice dated X by X, DO, the request for X was denied. Rationale: "No, the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. The Official Disability Guidelines conditionally recommended conditionally recommends X. Official Disability Guidelines recommends X. The surgery is indicated for X. While the claimant may benefit from the request, the medical records does not show evidence of official imaging results to substantiate the necessity of the requested surgery. As such, the request of X , is non-certified. "The requested surgical procedure is not medically necessary. The actual imaging reports have not been submitted for review to determine the necessity of the requested surgery. In addition, the requested surgery does not meet the associated guidelines as there is no indication of a X. No new information has been provided which would overturn the previous denials. X is not medically and non certified

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

The requested surgical procedure is not medically necessary. The actual imaging reports have not been submitted for review to determine the necessity of the requested surgery. In addition, the requested surgery does not meet the associated guidelines as there is X . No new information has been provided which would overturn the previous denials. X is not medically 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