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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 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 biomechanics of the injury is not available in the records. The diagnosis was chronic left foot and ankle pain following traumatic crush injury with subsequent failure to relieve pain and dysfunction with surgical intervention, secondary biomechanical dysfunction with myofascial pain of the lumbar spine. On X, X, DO evaluated X for continued care regarding X chronic left leg lower extremity traumatic injury complicated by neuropathic pain. X was X stimulator with excellent coverage of X leg, foot and ankle pain complaints, less swelling and less sensitivity to touch. X did have problems; however, at the battery site in X flank area. As a result, Dr. X recommended X. It was not uncommon that invasive complex regional pain syndrome (CRPS), a chronic inflammatory neuropathic pain condition could invade hardware. As a result, X. A X about the X was recommended. X was getting good relief in X desired area. X was walking on a daily basis. X use of medicines had come down to just a X. X effect had improved. Continued active X. On X, X was evaluated by Dr. X for follow-up of X. X stimulator was working extremely well. X got X back to work, activities of daily living, and reduced X narcotic load. X was more than X improved regarding X foot and ankle pain. Unfortunately, X right flank area continued to be tender. X were elicited across all X. This was not uncommon. The hardware often became a source of neuropathic pain and spread of CRPS. Already, X had offered X some vasodilation and pain relief; however, due to the X. Otherwise, they were going to have more the battery site. X was in moderate pain at the site. There were X. An MRI of left lower extremity dated X, revealed findings of common X. There was X. An MRI of left knee dated X, revealed X. There was slight thickening noted of the X. However, X was present. There was X. X was evident. There was X. There was X. There was X. Treatment to date included X. Per a peer review report dated X and utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “The request for X is not medically necessary. The injured worker has X. X has a X. X had a recent X. X continues to have some pain in X. Given there is no documentation of X was not documented, the request for X is not medically necessary. “An appeal letter dated X is included in the records for the reconsideration for X. Per a peer review report dated X and reconsideration / utilization review adverse determination letter dated X by, X, DO, request for X

was denied. Rationale: “This is non-authorized. The request for X is not medically necessary. Based on the documentation provided and per the ODG guidelines, the requested X is not recommended at this time. Though the injured worker has a history of continued pain at the X. As such, the request is not recommended in this case. “Thoroughly reviewed provided records including peer reviews and appeal letter. Patient with pain around site of X. X appears to have X. Based on cited criteria (ODG) for X appears warranted. However, X are not routinely used for X as there is no demonstrated benefit with high quality studies when using X. X is medically necessary and certified. 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:**

Thoroughly reviewed provided records including peer reviews and appeal letter. Patient with pain around site of X. X appears to have X. Based on cited criteria (ODG) for X appears warranted. However, X. X is medically necessary and certified. X is not medically necessary and non-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**
- ☒ **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)**