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Notice of Independent Review Decision
Amended Letter x

IRO REVIEWER REPORT

Date: X; Amended 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 was identified as a result of a X. The diagnoses were osteoarthritis of the right ankle due to the trauma and ankle pain. X was seen by X, MD on X for a follow-up of right ankle pain. X was wearing Arizona braces on the day of the visit and also regularly but they were quite bothersome. X was still having pain and reported the X had not helped to reduce X symptoms. X had been working without restrictions and not having trouble with it. X noted X years prior X had a X. X had no pain in X right ankle until X incident on X. On examination of the right lower extremity, X was noted. There was X. The range of motion of the right ankle was -X. Muscle strength was X in X. X was noted. X intact throughout. X were noted. An MRI dated X showed X. Incompletely X was noted. X was noted. There was X. X visited X, DPM on X for a follow-up of right ankle pain. X stated X had obtained the X and had been using it as directed. X had more pain while using the X than X did using the X. On examination of the right lower extremity, X was noted. There was X. The range of motion of the right ankle was -X. Muscle strength was X in X. X was noted. X was grossly intact throughout. X were noted. An injection of X was administered in the right ankle joint. Treatment to date included use of X. Per a utilization review adverse determination letter 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 do not recommend X On X, the claimant presented with right ankle pain. X wears X regularly, but they are quite bothersome. X is still having pain and reports the X have not helped to reduce X symptoms. X has been working without restrictions and not having trouble with it. Right lower extremity examination showed X. Right ankle ROM was-X. MRI showed X. There are no exceptional clinical findings that will support going beyond the guideline's recommendations. As such, the request for X is non-certified." Per a utilization review / reconsideration review adverse determination letter 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. The Official Disability Guidelines do not recommend X. The claimant was complaining of right ankle pain. Objective findings were documented during the assessment. However, the guideline does not recommend any type of X for ankle and foot conditions. Thus, the request for X is noncertified."

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

Official Disability Guidelines do not support the use of X. The claimant has had prior X that had not helped to reduce X symptoms.
Based on review of the submitted medical records, the request for X is not medically necessary.

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)**