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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 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. No mechanism of injury was available in the provided medical records. The diagnoses were localized swelling, mass and lump, right lower limb, and spontaneous rupture of flexor tendons, right ankle. Please note, no office visits or imaging were available in the provided medical records. Per a utilization review adverse determination letter dated X by X, DPM, the request for X was denied. Rationale: "The Official Disability Guidelines recommend the X. On X, the claimant was seen for a follow up visit and reported that there are X. On exam, right leg noted with previous X. X, there was a X. There was X noted and pain with palpation. X was X. The claimant is X on X. While there is documentation for X therefore the medical necessity for this procedure is not established at this time. Partial certification is not permitted in this jurisdiction without peer-to-peer discussion and agreement. As such, the request for X is noncertified. "Per a reconsideration review adverse determination letter dated X by X, DPM, the request for X was denied. Rationale: "Based on review of the medical records provided, the proposed treatment X DOS: X is not appropriate or medically necessary for this diagnosis and clinical findings. Given the nature of the X is not described, and the rationale for removal, in the setting of multiple recurrences, is not given, medical necessity is not established. Therefore, the request for X is not appropriate or medically necessary for this diagnosis and clinical findings. "The requested X is not medically necessary. The medical records do not demonstrate functional limitation associated with the mass. The mass does not appear to be X. No new information has been provided which would overturn the previous denials. 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 is not medically necessary. The medical records do not demonstrate X. The mass does not appear to be X. No new information has been provided which would overturn the previous denials. 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

☐ 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