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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 is a X who was injured on X at work when X was doing a physical agility test. X took off running and felt a pop to X right calf area with pain. X did not fall. Afterwards, X could not walk. The diagnosis was rupture of right Achilles tendon. On X, X presented to X, MD for evaluation of right ankle pain. X reported to the emergency department (ED) on X for right Achilles tear. The injury occurred while X was on the job. X voiced a X pain in the extremity. The pain was about X Achilles and calf. X voiced swelling and bruising of the lower leg. X had been non weight bearing on crutches. On examination, the pain score was X. X was in no acute distress. Right lower extremity revealed X. The assessment was X. Treatment options were discussed. X elected to proceed with X. On X, X seen by X, PA-C for a follow-up of X right Achilles tendon tear. X reported intermittent right ankle pain that increased after walking and resolved with rest. There was swelling without redness to the ankle. X was seen by orthopedics on X and surgery was pending. X was off work. On examination, X was alert and in no acute distress. X was not examined that day. X ambulated using a walker boot and crutches. The assessment was X. X was to follow instructions from orthopedics, elevate the ankle, use boot and crutches, and take X as directed. Ultrasound of the right lower extremity dated X showed a X. This may represent a X. Other etiologies were not excluded depending on the clinical scenario. MRI of the right ankle dated X demonstrated a X. The torn portion of the tendon appeared retracted proximally just past the ankle. No full-thickness X was noted. There were no additional findings of X. X-rays of the tibia and fibula dated X showed X. X-rays of the right ankle dated X revealed findings compatible with stated history of Achilles tendon tear. Treatment to date included X. Per

a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Per ODG, “ODG Indications for X: most X. X should be considered only for patients with X. 1. X 2. X 3. X 4. X 5. X 6. X.” In this case, the patient is X. On X, the patient reported having intermittent pain in X right ankle area that was aggravated by movement and alleviated with rest. X also had swelling and bruising with intermittent tingling to X toes. X had been wearing walker boots and using a crutch. X was given X. There is no indication that the patient was unresponsive to non-surgical treatment such as activity modification, medications, and/or brace/cast. Further, there is no evidence of any chronic tear that would support the need for surgical procedure. Therefore, the medical necessity for X is not established and the request is not certified. “Per a reconsideration review adverse determination letter dated X, by X, MD, the appeal request for X was non-certified. Rationale: “ODG by MCG X "Nonoperative management is preferred, with X. Mild functional deficits should be expected regardless of treatment. Surgical techniques are open, percutaneous, mini-open, and augmentative. Biologic adjuncts are not supported by quality evidence. ODG Criteria ODG Indications for X: Most Achilles tendon ruptures benefit from X. Surgery should be considered only for patients with X. 1. X 2. X 3. X 4. X 5. X 6.. With documented X is also a recommended procedure. ODG Criteria ODG Indications for X: Diagnosis of chronic insertional or non-insertional Achilles tendinopathy, with or without equinus deformity. 1. X 2. X 3. X 4. Imaging Clinical Findings: X." In this case, this request was previously noncertified by Dr. X. The requested X is not medically necessary. The records do document the presence of an X. The patient's functional demands are unknown at work. There is no documented attempt at X. As such, the guidelines have not been met. Therefore, the request for an appeal: X, is upheld and non-certified. “Based on the claimant’s diagnostic reports, there is a X. The records did not detail failure of non-operative measures for X. It is also noted that the claimant underwent X. There are X. Therefore, it is this reviewer’s

opinion that medical necessity for the surgical request is not established and the prior denials are upheld. 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:

Based on the claimant's diagnostic reports, there is a X is present. The records did X. It is also noted that the claimant underwent X. There are X. Therefore, it is this reviewer's opinion that medical necessity for the X is not established and the prior denials are upheld. 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**
- ☒ **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)**