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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 DECISIONX

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. X reported that X lost X limb due to a work-related accident. The diagnosis was acquired absence of right leg below knee. On X, X was evaluated by X, MD / X, MD. X was now approximately X years status post right BKA. X had not been taking anything for this or doing any therapy for this. X also stated that one of the X in X X. It had also been irritating X knee recently. X had an appointment with X prosthetists that afternoon to address this. On examination of the X. It was assessed that X was doing well overall and would be referred to X. They would also provide X with a prescription for X. X would be seen back in X year. On X, X underwent a right below-knee evaluation by X. X reported X lost X limb due to a work-related accident. X stated X had been wearing a prosthesis for X years and reported having issues with X. First, X said X had been X. Also, X stated the X did not work anymore. X stated X was currently unemployed but was looking to go back to work. X stated X lived with X brother, who was usually at work and did not see X very much. X would like to get back to hunting and fishing, which X had not been able to do, since X amputation. It was noted that X was a X. X had been wearing a X. X stated X usually X. X is a X. X was able to walk with a variable cadence. X did not have any health issues or any problems with X sound side. X had full range of motion in the right knee and hip. MMT=X in X right knee for flexion and extension. X ongoing X. X liked X current set up of the X. X said that the current set up helped X get around easier at home. X lived in the country and ambulated consistently on uneven terrain. The X did not work anymore and the foot was now out of warranty. The recommendation was to get X a X. The X. X needed a more X. X wanted to use the X. They needed to order a X. OWW had X on file. Authorization was needed before proceeding. Treatment to date included below-the-X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was non-certified. Rationale: “The injured worker was diagnosed with acquired absence of the right leg below the knee. The requested X is not medically necessary at this time. The submitted X is illegible. Further clarification and information is required. A peer-to-peer was attempted, however unsuccessful. As such, the guidelines have not been met. As such, the request for

X is non-certified. “In a letter of medical necessity dated X, Dr. X documented that X presented with X. X wanted to receive a X. X lost X limb due to a workplace related accident approximately X years ago. X did experience some phantom pain. X stated X was unemployed at the time but was looking to go back to work. X lived with family but was independent in all of X daily activities of daily living. X would like to get back into hunting and fishing, which X had not been able to do since X. X needed a X. X said that the ongoing set up helped X get around easier at home. X lived in the country and ambulated consistently on uneven terrain. The X did not work anymore, and the X was now out of warranty. Dr. X recommendation was for X to get with X X. The X needed to be replaced due to X loss in volume and would benefit from a more X. CPO recommended that X. Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “Based on the documentation provided, the injured worker presented for X years. On X, the injured worker presented to X, MD, for X. The injured worker was noted as doing well. The injured worker has X. The injured worker states that one of the X. It is irritating the injured worker. The injured worker has not been doing therapy for this. The physical exam was unremarkable. Guideline criteria cannot support the medical request per ODG. "A X may be considered medically necessary when: The patient will reach or maintain a defined functional state within a reasonable period of time." Since there was no documentation of the injured worker’s functional capabilities or reasonably defined functional state, the medical necessity cannot be established. Therefore, the request for X is non-certified. “The claimant had continued to report X. The X evaluation did not identify any specific issues with the claimant’s current X. A letter of medical necessity dated X stated that the claimant was needing a X. The provided prosthetics evaluation is illegible and a poor copy quality. It is unclear why an X. Therefore, it is this reviewer’s opinion that medical necessity is not established and the prior denials are upheld. X.

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

The claimant had continued to report X. The X evaluation did not identify any specific issues with the claimant’s X for the right lower extremity. A letter of medical necessity dated X stated that the claimant was needing a X. The provided

X is illegible and a poor copy quality. It is unclear why an X. Therefore, it is this reviewer's opinion that medical necessity 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)**