



Physio
Solutions LLC
7500 Brooktree
Rd STE 300
Wexford, PA 15090

Notice of Independent Review Decision

X

Amended Decision Date: X

Date Amended Decision Sent to All Parties: X

RE: IRO Case number **X**

Name: **X**

Coverage Type:

- Workers' Compensation Health Care Network
- Workers' Compensation (non-network) if applicable, decision must include specific basis for divergence

from TDI/DWC policies or guidelines

Type of Review:



Preauthorization

Review

Concurrent

Review

Retrospective

Review Prevailing

party (if applicable):



Request

or

Carrier

IRO

Reviewer

Report X

IRO Case number: X

Description of the services in dispute

X

Description of the qualifications for each physician or 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:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

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

X, date of birth X, is a X individual diagnosed with strain of muscle and tendon of peroneal muscle group of lower leg and strain of muscle and tendon of the left foot/ankle and seeking coverage for X.

The claimant is a X whose date of injury is X. X was walking quickly when X left foot got caught in a hose, causing X left ankle to hyper

plantarflex, making X body fall forward to the ground. X-rays of the left foot and ankle were normal. The emergency room (ER) prescribed a walking boot, which was too heavy, and X could not walk with it. A follow-up note dated X by X, FNP-C, indicates that the claimant is having physical therapy on X left ankle x 3 per week.

A physical therapy re-evaluation by X, PT, dated X, indicates the claimant presents with left foot/ankle pain. X reportedly got a shot in X back, and it helped for a while, but now that it is wearing off, X skin feels weird, X toes are curling, and X second toe keeps going under the big toe. X has to wear X custom ankle-foot orthoses (AFO) with tennis shoes only. X has fallen X times when not using it. The pain is rated X. The claimant reports pain limits activity by X. Objective examination reveals the left ankle rests in full plantar flexion, and dorsiflexion passive range of motion is lacking X degrees. Left ankle strength is rated X for dorsiflexion, X for plantarflexion, X for inversion, and X for eversion. There are paresthesias in the left lateral lower leg, foot, and toes.

Per a Designated Doctor Exam by X, BS, DC, CEDIR, dated X, the claimant previously reported a X improvement in left ankle symptoms following the injection procedure with a slightly improved range of motion and sensation. X reports left foot/ankle pain rated X on average. An exam of the left foot/ankle notes tenderness to palpation over the distal lateral lower leg and ankle and the dorsal and lateral aspect of the left foot. Curling of the left X toes is noted when standing. There is mild/moderate reaction to palpation. The left ankle range of motion notes X degrees of plantarflexion, X degrees of dorsiflexion, X degrees of inversion, and X

degrees of eversion. The stability of the ankle/foot is ligamentous intact. There is reported paresthesia over the dorsal aspect of the left foot and digits X. Deep tendon reflexes are X in the lower extremities except X in the left patella. Strength is X for tibialis anterior, X for extensor hallucis longus, and X for peroneus on the left. Diagnosis is strain of unspecified muscle and tendon at lower leg level left leg. The claimant was determined to have reached maximum medical improvement as of X. It is opined that there is no additional avenue of medical procedure to be performed on the left ankle/foot to expect any further medical recovery.

The initial request was non-certified, noting that “This compensable injury is now X months old. The number of formal physical therapy sessions completed post-injury to date with their outcome were not documented. Insufficient clinical information was furnished to establish medical necessity. Therefore, the request for X is non-certified.”

The denial was upheld on appeal, noting that “In regards to requested X, as stated in the guidelines, X is recommended and that given X. The ODG guidelines allow for X. Guidelines indicate that for X. The guidelines recommend that X. In this case, the clinical summary states that prior treatments include X. It is recommended that X. In this case, it is unclear what extraordinary circumstances exist in which it would be necessary for claimant to have X. It is unclear why claimant X.”

Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision

The request for X is not recommended as medically necessary. Current evidence-based literature notes that X. The Official Disability Guidelines would support X. There is no information provided

regarding X. There are no X. The request for X. The submitted clinical records indicate that the claimant has been determined to have reached maximum medical improvement by a designated doctor as of X. It was opined that there is no additional X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines, and the denial is upheld.

Description and source of the screening criteria or other clinical basis used to make the decision

ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase AHRQ -

Agency for Healthcare Research and 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 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)