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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 Overturned (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. X was walking outside the X. The assessment included tear of peroneal tendon, right, subsequent encounter; sprain of anterior talofibular ligament of right ankle, subsequent encounter; and closed avulsion fracture of lateral malleolus of right fibula with routine healing, subsequent encounter. X was seen by X, MD on X for a follow-up of right ankle complaints. X complained of pain along the anterior, lateral, and posterior lateral aspects of the ankle. X stated that X was unable to sleep secondary to discomfort. X was placed in a X. X had been X. X did live on the second floor and stairs were very difficult for X. An MRI was due to the amount of swelling and pain along the peroneal tendon. On examination, X BMI was 45.19 kg/m<sup>2</sup>. Examination of the right foot / ankle showed X. X was noted. There was X. X was noted throughout. Treatment plan was to proceed with X. An MRI of the right ankle dated X com plains of right-sided ankle pain. However, there has been no previous treatment wed X. There was X. X was well maintained. X were noted. There was X. X changes in the X were noted. There was X. X-rays of the right ankle dated X showed an X. X were noted. X was well maintained. X were noted. Treatment to date included X. Per a utilization review adverse determination letter dated X; the request for X was denied by X, MD. Rationale: "The Official Disability Guidelines would support X. There should be X of on examination. This claimant has continued X. X are present. Physical examination does X. Absent these objective findings and conservative care, this request for a X is non-certified. Peer to peer was unsuccessful. "Per a reconsideration review adverse determination letter dated X; the prior denial was upheld by X, MD. Rationale: "The Official Disability Guidelines X. The ODG supports X. The ODG X. In this case, the claimant reports acute right ankle pain.

Treatment has included a X. An exam of the right foot and ankle documented X. An MRI documented a X. When noting that there has been X. Additionally, there is X. Therefore, the request for X, is not medically appropriate, and the recommendation is for non-certification. Peer to peer was unsuccessful. "Based on the submitted medical records, the requested X is not medically necessary. There are X. No new information was 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:**

Based on the submitted medical records, the requested X is not medically necessary. There are X. No new information was provided which would overturn the previous denials. Repair of the 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)**