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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 sustained an injury on X. X noticed pain in X right ankle due to walking back and forth at work for about X miles a day. The diagnoses included acute right ankle pain and right ankle sprain. X was seen by X, MD on X for a follow-up evaluation of right ankle. X reported some persistent pain in the X. X continued with X. X symptoms had improved compared to the prior visit. X reported some pain in the area of the X. X body mass index (BMI) was 23.62 kg/m². Examination of the right ankle revealed X. Ankle range of motion was X degrees dorsiflexion and X degrees plantar flexion. Strength was X. On X, X underwent physical therapy evaluation by X, PT. X reported pain in the right foot / ankle rated X. X had a chronic history of right ankle pain. The pain exacerbated at the beginning in X. X could not recall a specific mechanism of injury, but began to feel it after walking for prolonged period of time at work. X got progressive worsening of pain over the next few weeks after that. X went to MD and placed in a X. X had difficulty with prolonged standing, walking, and managing stairs. X was restricted to walking no more than X hours per day under MDs orders. X rated X pain X. On examination, Lower Extremity Functional Scale (LEFS) score measures at X and Orebro Musculoskeletal Questionnaire at X. Active range of motion of right ankle dorsiflexion measured at X degrees, eversion at X degrees, inversion at X degrees, and plantarfiexion at X degrees. Strength of right ankle dorsiflexors was graded X evertor at X, invertor at X, plantar flexors at X, and toe flexors at X. Single leg stance with the left leg at X seconds and right leg at X seconds. X was restricted to walking no more than X hours per day under MDs orders. Assessment indicated that X required X. Overall, X rehabilitation potential was good. An MRI of the right ankle on X revealed X. Treatment to date included X. Per Adverse Determination -- Utilization Review by X, MD on X, the request for X was non-certified. Rationale: “ODG Physical Therapy Guidelines recommend X. When treatment duration and/or number of visits exceeds the

guideline recommendation, exceptional factors should be noted. Claim review reveals that the claimant has been X. In this case, the claimant has completed the X. Thus, the request for X is not medically necessary. Recommendation is to deny this request. “Per Appeal / Reconsideration Determination -- Utilization Review by X, MD on X, the request for X was non-certified. Rationale: “The request for X is not recommended as medically necessary. The submitted clinical records indicate that the claimant has been authorized for X. I spoke with Dr. X, who was unable to say whether or not the patient had completed the X. In addition, this provider’s last exam dated back to X. In light of this information and realizing that the patient was injured back in X, we agreed to have the patient come back in and be re-examined to initiate any X. I encouraged this provider to proceed with a X. Dr. X conceded and agreed. Therefore, after discussion and review of this case, I do not recommend certifying this request. “X is not supported by the submitted medical records for the associated diagnosis. The patient has already completed an appropriate amount of X. The patient should be well versed on a 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:

X is not supported by the submitted medical records for the associated diagnosis. The patient has already completed an appropriate amount of X. The patient should be well versed on a 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