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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a X who sustained an industrial injury on X. The injury occurred while the individual was on a X. According to the functional capacity evaluation dated X, the individual's occupation job-demanded physical demand level is heavy. X was currently performing at medium. There was also documentation of X right foot and ankle pain and swelling. The intensity of the pain was rated as X. Prolonged walking, flexing the ankle, and turning and twisting the ankle, increased the overall pain level. Massage and rest alleviated the overall pain. The gait evaluation revealed an X. Palpatory examination of the right foot and ankle revealed X. There was also pain in the anterior tibia from about the midpoint and distally. The neurological examination for deep tendon reflexes revealed X. Sensory revealed X.

According to the mental health evaluation visit on X, those documentation of stress and

anxiety. The individual had no history of psychological intervention and had been treated with X. The individual voice and demeanor reflected a high level of frustration and depression. The individual PHQ-9 score was X, indicating moderate depressive symptoms, and made it difficult to complete daily life tasks, take care of things at home, or get along with others. The individual had little interest or pleasure in doing things, felt down, depressed, or hopeless, had trouble, falling asleep or staying asleep or sleeping too much. Based on this evaluation, the individual was X.

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

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition:
Chapter: X: Recommended as an option, depending on the availability of quality programs, using the criteria below.

X

In this case, the individual has not yet completed all the lower levels of care prior to the consideration of a X. The individual had prior right foot fracture repair on X, and continues to have decreased range of motion and weakness

of physical exam. The date of injury is no more than X years, and the individual has continued deficits that preclude ability to safely achieve current job demands. Per the X, letter, the X. However, given documentation ongoing postoperative physical therapy, treatment, and use of an X device, it is unclear why the individual is not a candidate for other treatments that will improve their functions. Therefore, this request for a X is not medically necessary.

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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY 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)**