

CPC Solutions

Notice of Independent Review Decision

Case Number:
Notice: X

X Date of

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

X

Description of the service or services in dispute:

X

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

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Patient Clinical History (Summary)

The patient is a X whose date of injury is X. The patient injured X left foot/ankle when X. X sustained a X. X has had X surgeries including X. The most recent surgery was X. X is diagnosed with left peroneal tendinitis. X of the left leg and status X. Office visit note dated X indicates that the claimant had X. There is a pain in my left foot and ankle. The claimant is utilizing medication. The physical examination revealed X. There is X. Still exhibits some weakness with muscle testing and there is X. X is mildly analgic and propulsive. The claimant was diagnosed with Peroneal tendinitis, left; X, left leg; and Status X. Treatment plan was for X. Daily note dated X indicates X underwent X on X. X has some pain around posterior tibialis tendon, intermittent, short-lasting. On physical examination left ankle range of motion is X, inversion X and eversion X degrees. Strength is X inversion and eversion.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. The initial request was non-certified noting that, "In this case, the claimant has X. The request is for an X. However, there is no documentation for a successful trial with documentation of at least near daily use by providers and improved pain and function using the device. Thus, the request is not certified." The denial was upheld on appeal noting that, "Per Official Disability Guidelines, Pain; Foot, Online version, X, X, Recommended as an option; may be a first-line or second-line option. ODG Criteria. X. Treatment course, as indicated by I or more of the following: X. Failure of symptoms to improve after I or more of the following: X for X months. Treatment with

medication (X. Physical therapist discharges patients from care due to lack of utility of further treatment. Worsening pain despite treatment with X. Continued treatment (X months) when ALL of the following are present: X." In this case, based on the documentation provided, the Official Disability Guidelines, Pain Chapter, Online Version, updated X, X, is not satisfied. There is no documentation for failure of at least X months of X. Therefore, medical necessity has not been established." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The Official Disability Guidelines note that for continued treatment of X. The submitted clinical records fail to establish that this patient has completed a successful X.

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Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

ODG by MCG Pain Section

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A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um knowledgebase
- AHRQ-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and Guidelines
- European Guidelines for Management of Chronic Low Back Pain
- Internal 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 and Treatment Guidelines
- , the Medical Disability Advisor

Texas Guidelines for Chiropractic Quality Assurance and 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)