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Notice of Independent Review Decision

Amended and Sent on X

DATE OF REVIEW:X

Date of Amended Decision: 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 determination 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]:

The patient is a X with a date of injury on X. Mechanism of injury X. Patient sustained a right ankle fracture. X underwent an ORIF of right ankle on X. Patient continues to complain of pain in the right ankle with radiation to the right knee. Patient was subsequently diagnosed with S/P right ankle fracture, chronic pain syndrome and right saphenous neuropathy. X pain is rated X and the pain increases by the end of the day with associated burning and numbness at the medial aspect of the leg and lateral aspect of the foot. Symptoms aggravated with activity and

standing and improved X, also patient X. Patient had an EMG on X that showed no response at the right saphenous nerve. Patient did undergo a X with some relief that lasted for one week. Physical exam revealed X. There was reduced sensation, temperature and vibratory sensation up to the level of the right knee. Right Achilles and patellar tendon reflexes were absent.

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

Per ODG references the requested X is not medically necessary.
According to the ODG references, X is not recommended for chronic pain conditions. Also, the guidelines indicate that literature studies have not demonstrated any consistent reproducible objective functional benefit with X. Therefore, the X not certifiable.

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 KNOWLEDGE BASE
- ☐ AHCPR- 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