True Decisions Inc.

Notice of Independent Review Decision

True Decisions Inc.
An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #615
Mansfield, TX 76063
Phone: (512) 298-4786
Fax: (888) 507-6912
Email: @truedecisionsiro.com

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 is a X who was injured on X. The mechanism of injury was a trip and fall injury

where while running, X tripped on a candidate and fell, rolling X right ankle. The diagnosis was complex regional pain syndrome type I and pain in right foot.

On X, X, MD evaluated X for lower extremity problem. X reported pain in the right foot since 4 months, described as aching, gnawing, stabbing, throbbing, and numbing. The pain was rated 7/10 and worst pain was 9/10. X was involved in a work-related injury that occurred on X. Aggravating factors included standing, walking, range of motion, and exercise. Alleviating factors included physical therapy (PT) / occupational therapy (OT), medication, nonsteroidal anti-inflammatory drugs (NSAIDs), salon pas, and dry needling. Associated symptoms included weakness and numbness. X had been having some significant pain in X foot, which started in X, after a work-related accident. X stated X was running and tripped on a candidate, falling, and rolling X ankle. X sustained a fifth metatarsal fracture, in the right foot that X heels as well as a sprained foot and ankle. Despite healing of X fracture, X had experienced significant swelling, coldness in the right foot discoloration, numbness, and allodynia. X denied any sweating, hair changes, and nail changes. X had been bridges breathing and extensive physical therapy with desensitization without durable relief. X really wanted to avoid medications if possible. X presented that day stating that X had achieved significant relief after undergoing a X in X. X stated that X hypersensitivity continued to diminish, and Xe was able to perform X home exercises much more easily. X was frustrated that X was discontinued because X was making great progress with X. X would like to see if X could continue this. At that time, X pain resided most prominently in the arch but did vary in terms of its location. Overall, it was very much narrowing down in scope. On examination, L5 motor strength on the right revealed ankle dorsiflexion tibialis anterior was 4/5. There was tactile decrease in distal extremities. The right foot showed improved allodynia to light touch and light palpation, cold temperature compared to the left, swelling compared to the left, discoloration compared to the left, numbness throughout the right foot, and slight weakness with right ankle dorsiflexion. The diagnosis was complex regional pain syndrome (CRPS) of the right foot. Dr. X wanted to be aggressive in the management of this condition in an effort to decrease permanent impairment and in an effort to return X to full-duty work. X reordered X.

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Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD, as not medically necessary or appropriate. Rationale: “The ODG supports X for the treatment of a foot sprain for X. This is a X who was injured on X with ongoing intermittent foot pain for which treatment has included X. X have been completed before more planned X have been completed. There is no documentation of continued objective deficits or a barrier to a home exercise program to support additional requests when X exceeds the guideline recommendation. As such, the request for X is recommended for noncertification.”

Per a reconsideration review adverse determination letter dated X, the appeal request for X was modified by X, MD. Rationale: “This is an appeal request for X. The initial denial for additional rehabilitation as there is no evidence of continued objective deficits or a barrier to a home exercise program to support additional requests when the current number of X already exceeds the guideline recommendation. In an independent review of the documentation available, the documentation does not identify functional deficits and does not provide evidence of improvement over X. The documentation only provides a few goals and notation of "Progressing". The Official Disability Guidelines clearly outlines criteria necessary for continuation of treatment. Due to a lack of information and absence of barriers to continuing improvements in a home PT program (HEP), a medical necessity is not established. A phone call to the office of X, MD at X was placed on X. The provider was unavailable. However, a conversation was held with X, PT regarding the requested care, which included the claimant has developed reflex sympathetic dystrophy (RSD) and has had X and is scheduled for X and has X. As guidelines recommends X, it would be supported by guidelines to approve X, so that the claimant can have X. Consensus agreement reached on modification of request. Recommend X and certification.”

Based on the submitted medical records, the patient has already completed X. The patient should be well versed on a home exercise program. X is not supported on the documents received. 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:
Based on the submitted medical records, the patient has already X. The patient should be well versed on a home exercise program. Additional therapy is not supported on the documents received. 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:

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

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☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE