Maximus Federal Services, Inc.
807 S. Jackson Road., Suite B
Pharr, TX 78577
Tel: 956-588-2900 ◆ Fax: 1-877-380-6702

Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: 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

1. X.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case concerns a X for whom authorization and coverage for X. The Carrier denied this request on the basis that the service is not medically necessary for treatment of the member's condition.

A review of the record indicates that the member's past medical history was not documented. X past surgical history was X. Previous treatments completed included X.

The X of the left foot had impressions of X.

The X treating physician report cites the member completed a X and it was determined that the member should X. This will assist in ruling out an X. X had pain rated X out of X of the left foot and left toe with movement, activity, and prolonged walking or standing. The pain and swelling worsen towards the end of the day. The exam reveals pain and swelling to the left foot. There was moderate swelling. Tenderness to palpation over X metatarsals. Range of motion had increased but not at baseline. Soft touch sensation to the X is absent. Strength had decreased to X. The treatment plan included X.

The X specialty care clinic report cites X still had pain. X was X of this foot and has pictures of severe swelling. The exam revealed X. X had mild pain over the proximal middle and distal phalanges of the X toe and pain proximal phalanx and proximal interphalangeal joint (PIP) joint of the X, and pain over the lateral sesamoid great toe. Pain was noted over the plantar surface of the great toe. X ambulates with post-operation shoe with mild antalgic gait. X was provided with an X between the X and X web spaces. X needs an X of the left foot due to X.

The X treating physician report cites a work-related injury on X. X left foot was X. X had X of the left foot and given an X. X was referred to an X for an evaluation on X and released back to work. X presented still in the X. X had a designated doctor notice. X had a X ordered by another provider, which is still not approved, and this had delayed healing. The X is a medical necessity to promote healing process. X presented on the day having completed X. The X was denied and will be ordered again. It is very clear that X has edema and swelling that is not resolved. The soft tissue needs to be re-evaluated, and a X would not be specific. The bones are healed and the soft tissue is not. Also being ordered was an X and anticipating the need for a X. X was not functionally ready for X labor-intensive job duties and there was psychological component of fear of reinjury. X was advised to wear X. X pain was rated X out of X and X continued with numbness and swelling complaints that were unchanged. X complained of left foot and toe pain with movement, activity, and prolonged walking and standing. The pain and swelling worsen at the end of the day. The exam reveals pain and swelling to the left foot. There was moderate swelling at X. Tenderness to palpation is noted over the X. Range of motion had increased but not at X. Soft touch sensation to the X. Strength has stabilized at X. Previous imaging included X of the left foot on X with X. X of the left foot dated X had X. The treatment plan included a X.

The X utilization review report non-certified the X of the X. The rationale stated that the member had not had a recent X and considering X was placed at MMI on X, the medical necessity was not established.

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

As per Official Disability Guidelines (ODG), X. As well as prior imaging results of specific area or structure with same imaging modality documented and available for comparison.

The X consultant explained that the member is X. A review of records indicated the member was being treated for X.

The X explained that the member's pain was rated X out of X and X continued with numbness and swelling complaints that were unchanged. X complained of left foot and toe pain with movement, activity, and prolonged walking and standing. The pain and swelling worsen at the end of the day. The exam revealed X. There was moderate swelling at X. Tenderness to palpation was noted over the X. Range of motion had increased but not at X. Soft touch sensation to the X. Strength stabilized at X.

The member had X, X of the left foot had X. However, there had not been clear documentation of a change in clinical status as evidenced by worsening symptoms or new associated symptoms, a need for interval reassessment that could impact treatment plan, or a need for X.

The request for the X was to assess for the edema and swelling. However, it is not clearly documented to have worsened since the X. The member was noted on the X report to have been "X". However, the date of the incident is not documented. There has not been clear documentation of a significant increase in swelling after this incident. Also not indicated, is how the X would change the current treatment plan. Therefore, based on ODG guideline criteria, the X of left foot is not medically necessary for treatment of the member's condition.

Therefore, I have determined that the requested X is not medically necessary for treatment of this member's condition.

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)**