

Independent Resolutions Inc.
An Independent Review Organization
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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

Independent Resolutions Inc.
Notice of Independent Review Decision

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured at work on X when X sustained a X. The diagnosis was sprain of right ankle, unspecified ligament, subsequent encounter, and obesity with body mass index 30 or greater.

X underwent X by X, PT on X, for X. On examination, pain was rated X; there was tenderness to palpation over the lateral aspect; right ankle range of motion was within functional limits with some stiffness at inversion end range of motion; and manual muscle testing was within functional limits but with decreased endurance. It was assessed that X demonstrated good stability on examination with a X anterior drawer test. Persistent pain and functional limitations warranted X. The diagnosis was sprain of unspecified ligament of right ankle, initial encounter; and posterior tibial tendinitis, right leg. It was noted that signs and symptoms were consistent with the medical diagnosis. X showed impaired strength, range of motion/stiffness and pain resulting in decreased functional walking, pulling, climbing associated with right ankle strain. X would benefit from X. On X, X was seen by X, MD, for follow-up evaluation of the right ankle ligament injuries sustained in a work-related X. X reported significant improvement in ankle pain and function. X had completed X. At the time, X was back to full work X. X previously had lateral ankle pain with inversion movements and inability to return to gym activities. X now reported minimal to no pain with activities that previously caused discomfort. Right ankle examination revealed X. Dr. X noted that X demonstrated excellent recovery from X. X had significant functional improvement with X. Ankle stability was restored with X anterior drawer test and improved strength. The plan was to continue X. Dr. X recommended X. The

Independent Resolutions Inc.
Notice of Independent Review Decision

Case Number: X

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assessment was sprain of right ankle, unspecified ligament, subsequent encounter, and obesity with body mass index 30 or greater.

An MRI of the right ankle dated X, demonstrated X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "As per ODG X Guidelines The visit recommendations outlined below serve as benchmarks for the expected number and duration of X. Sprain, ankle or foot: Medical treatment: X. In this case, the requested X is not medically necessary for an ankle sprain. The guidelines only recommend X. The records reflect that the patient has X. The X. Medical necessity cannot be established. Therefore, the request for X is non-certified."

Per a reconsideration review adverse determination letter dated X, and an appeal review report, the appeal request for X, was denied by X, MD. Rationale: "Per Official Disability Guidelines, Ankle and Foot, MCG version (Last review/updated date: X), X, "Ankle: Medical treatment: X." In this case, the claimant has noted complaints of X. The physical examination revealed X. However, the claimant is noted to have had X. Therefore, this request is not medically necessary and is not certified."

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

In this case, the records for review indicate the claimant had X. The records document the physical examination revealed X. The records do not indicate X. The request for X is not supported by the submitted documentation. The ODG explains that patients should be formally assessed after a "X" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the X); and when treatment X. The request for X is not medically

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Notice of Independent Review Decision

Case Number: X

Date of Notice: X

necessary.

Non-certified.

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Notice of Independent Review Decision

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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
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE