

SENT VIA EMAIL OR FAX ON  
Jul/12/2011

## IRO Express Inc.

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

Amended 7/14/11

Date of Notice of Decision: Jul/12/2011

**DATE OF REVIEW:**

Jul/12/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Custom Splint: Static Progressive Finger Flexion, L3900 and L4205 X 4

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

Board Certified Orthopedic and Hand Surgery

**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**

OD Guidelines

1. Cover sheet and working documents
2. Utilization review determination dated 05/24/11, 06/09/11, 04/27/11
3. Encounter summary dated 06/15/11, 05/18/11, 04/27/11, 04/20/11
4. Progress notes dated 05/31/11, 04/20/11
5. Reference material
6. Patient face sheet dated 04/20/11
7. Pain management note dated 04/28/11
8. Prescription and letter of medical necessity dated 04/20/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was doing xx

with a pad when he felt pain to his left wrist. Treatment to date is noted to include wrist brace, cortisone injection and physical therapy. The patient underwent MRI of the left wrist; however, the results of this study are not provided. Radiographs of the left wrist reportedly show evidence of osteoarticular abnormality of the scaphoid nonunion with advanced collapse. The patient is noted to be developing CRPS type 1; however, it is noted to be early.

Initial request for custom splint: static progressive finger flexion was non-certified on 05/24/11 noting that there is no specified indication why a custom splint is required. The length of time of static progressive finger flexion is not specified. The denial was upheld on appeal dated 06/09/11 noting that there are no prior therapy notes submitted for review to assess the dates of service, duration and efficacy of treatment. The clinical documentation submitted for review does not indicate the duration and frequency of treatment.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

Based on the clinical information provided, the request for custom splint: static progressive finger flexion, L3900 and L4205 x 4 is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There are no radiographic reports/imaging studies submitted for review. There are no specific, time-limited treatment goals provided. As noted by the previous reviewers, the clinical documentation submitted for review does not indicate the duration and frequency of treatment and there is no clear rationale provided as to why a custom splint is needed. Given the current clinical data, the request is not indicated as medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**