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IRO Certificate #4599

**Notice of Independent Review Decision**

DATE OF REVIEW: 2/13/14

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Surgery on left hand ring finger; Repair of ulnar collateral ligament, CPT: 26545

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

Physician Board Certified in Orthopedic Surgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

<b>Upheld</b>	<b>(Agree) <u>X</u></b>
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Utilization Review Denial, 1/02/14.

Utilization Review Reconsideration, 1/17/14.

Medical Note: History & Physical; Request for procedure, 12/19/13.

Medical Note: History & Physical, Second request for procedure, 1/13/14.

ODG (Official Disability Guidelines)

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male claimant who evidently sustained an injury in xx/xxxx. Diagnoses included contusion of the finger. There were conservative treatment measures taken which included physical therapy and some over-the-counter medications, as well as modifying activities and some work restrictions. Records indicate an evaluation was done by a specialist on 12/19/13. There is no documented evidence of further conservative care on this patient despite both utilization review decisions recommending documentation of such. The requesting provider did not demonstrate this.

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

**Opinion**

I agree with the benefit company's decision to deny the requested service.

**Rationale**

Certainly, there is a chance this injury can heal without the need for surgical reconstruction or repair of collateral ligament. Surgery is very rare and is not demonstratively necessary in this case based on the medical records.

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

## **THE DECISION**

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL  
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH  
ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

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

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

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