I-Resolutions Inc.

An Independent Review Organization
3616 Far West Blvd Ste 117-501
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 790-2280
Email: manager@i-resolutions.com

Review Outcome

Description of the service or services in dispute:

XX XX XX XX to extensor XX XX XX (XX), XX XX XX XX XX to extensor XX XX (XX), XX XX XX XX to extensor XX XX (XX)
XX XX XX or XX, flexor or extensor, XX and/or XX, single; XX XX

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Orthopedic Surgery

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

- ☐ Overturned (Disagree)
- ☑ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XX. XX XX is a XX-year-old XX who sustained an injury on XX. XX XX XX the XX, XX XX, and XX XX on the XX XX and XX. XX was diagnosed with lesion of the XX XX, unspecified XX XX (XX.XX); XX by XX, initial encounter (XX.XX), and lesion of XX XX, unspecified XX XX (XX.XX).

On XX, XX. XX presented to XX XX, XX for a follow-up. XX reported XX XX pain, which was dull and rated 2/10. Examination revealed XX XX XX with XX XX XX. XX. XX placed XX. XX out of the work from XX through XX. XX recommended XX XX of XX XX to extensor XX XX XX (XX), XX XX flexor XX XX to extensor XX XX (XX), and XX XX XX XX to extensor XX XX (XX).

XX. XX was evaluated by XX XX, XX on XX. The XX XX XX examination showed strength of 3/5 at the XX and 0/5 on XX extension. There was painless active flexion at the XX (XX) and XX XX (XX) joints. The strength was 0/5 at extensor XX and 4/5 at XX XX.

X-ray of the XX dated XX showed healed displaced XX fracture. An undated electromyography revealed XX XX, XX, XX, extensor XX XX XX (XX), extensor XX, XX XX, XX XX, XX XX XX (XX), XX XX XX (XX), and XX XX XX (XX) – insertional activity was normal. There was 4+ sharp waves and fibrillations in the XX XX, XX, and extensor XX. No recruitment was noted from these muscles. All other muscles within normal limits.

Treatment consisted of medications (XX and XX); XX; XX therapy; and irrigation and debridement, surgical exploration, lateral XX XX XX XX on XX.

Per a utilization review decision letter dated XX, the request for XX XX XX XX to extensor XX XX XX (XX), XX XX XX XX XX to extensor XX XX (XX), XX XX XX XX to extensor XX XX (XX) was denied by XX, XX. Rationale: “Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per review of related literature, XX XX are used to address functional deficits. In this case, the patient complained of XX XX pain.

Examination showed XX XX XX with XX XX XX. The provider recommended XX XX XX XX to XX XX XX flexor XX XX to XX, XX XX XX XX to XX. However, the presented objective findings on the medical report were limited to warrant the need for the request. XX, XX, and finger range of motion testing is important since the full passive range of motion should be achieved before XX XX. Moreover, the actual report of abnormal electromyography (EMG) findings XX months from time of injury indicates a low likelihood of spontaneous recovery and XX XX may be considered."

Per a utilization review decision letter dated XX, the prior denial was upheld by XX, XX. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The presented objective findings on the medical report were still limited to warrant the need for the request. XX, XX, and XX range of motion testing is important since the full passive range of motion should be achieved before XX XX. Moreover, the actual report of abnormal EMG findings XX months from time of injury indicates a low likelihood of spontaneous recovery and XX XX may be considered. There were no recent progress reports submitted to overturn the previous denial. There were no pertinent clinical or extenuating circumstances that would require deviation from the guidelines, therefore this remains not supported."

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The ODG does not address this request for XX XX of the XX XX to the extensor XX XX XX (XX), XX XX of the flexor XX XX to the extensor XX XX (XX), or XX XX of the XX XX to the extensor XX XX (XX). The referenced article from *XX XX* indicates that in the absence of XX XX recovery, reconstruction of motor function involves XX XX surgery. The provided documentation indicates the injured worker has a XX XX XX of the XX XX XX, but the physical examination does not document any objective findings regarding motion to indicate if there is functional impairment or what the degree of functional impairment is if present. Based on the lack of objective findings, medical necessity cannot be established and as such, recommendation is to uphold the two previous denials. Given the documentation available, the requested service(s) is considered not medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic Low Back Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☐ ODG-Official Disability Guidelines and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters

Case Number: XX Date of Notice: 04/05/19

☐ Texas TACADA Guidelines

☐ TMF Screening Criteria Manual

☑ Peer Reviewed Nationally Accepted Medical Literature (Provide a description)
XX

☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

Appeal Information

You have the XX to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.