

Notice of Independent Review Decision

DATE OF REVIEW: X

Date of Amended Decision: 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

X

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X with a diagnoses of right elbow strain as well as flexor carpi radialis and tenosynovitis of the right forearm.

On X, the claimant was seen by Dr.X. X was known to be injured as a X. X was treated with an X on X. X had X. The treatment plan included discussion of options including X.

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

Per ODG references, the requested "X" is not medically necessary for the patient.

The Official Disability Guidelines discuss MRI imaging. MRI imaging of the elbow should generally be done to either rule in or rule out specific diagnosis.

Dr X report on X does not identify pathology that requires further MRI investigation and doesn't offer clinical rational for the need of an MRI. The right elbow exam findings included X.

It is not clear what diagnosis is to be found by MRI imaging nor is it clear how this is likely to alter the treatment plan. Without further clarification, the request is not medically necessary and should be noncertified.

**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 KNOWLEDGE BASE
- AHCPR- 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