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Notice of Independent Review Decision

Amendment X

Amendment X

IRO REVIEWER REPORT

Date:X; Amendment X; Amendment 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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]:
X who was injured on X. Per records, the biomechanics of the injury was described as

a crushing injury/ The diagnoses were contracture of right hand, crushing injury of right hand, unspecified fracture of right wrist and hand, subsequent encounter for fracture with routine healing. Comorbidities were documented as high blood pressure. Per indirect records from utilization review dated X, it was documented that progress note dated X indicated X had X. Physical exam of right hand noted a scabbed, almost fully healed wound over right index finger MP, decreased and painful range of motion, decreased grip strength, static band at index proximal joint, webspace contracture across index and mid de finger, stiffness throughout joints with inability to make a fist. Treatments had included X. On X, X underwent X was performed. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “The proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. Official Disability Guidelines conditionally recommends contracture release. Guidelines indicate contracture release X. Official Disability Guidelines does not address X. Current literature suggests the use of X. Physical exam of right hand noted a scabbed, almost fully healed wound over right index finger MP, decreased and painful range of motion, decreased grip strength, static band at index proximal joint, webspace contracture across index and middle finger, stiffness throughout joints with inability to make a fist. Information received with the claim indicated prior approval of requested X. While the requested X is a duplicate request, and unable to modify without peer to peer discussion. Therefore, the request of X, is non-certified. “Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the reconsideration request for X was denied. Rationale: “The proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. Official Disability Guidelines conditionally recommends contracture release for burns and wounds. Guidelines indicate contracture release for X. Official Disability Guidelines does not address X. Current literature suggests the use of X. Physical exam of right hand noted a static band at index finger limiting MP joint extension, webspace contracture across index and middle finger, with PIP joint contracture and stiffness most noticeable at middle and ring fingers. Treatments have included X. Records Indicate prior approval of requested X. Records indicate a duplicate request for previously approved X. Therefore, the request of X is non-certified. The requested X is not medically necessary. No new information or requested URA/Medicals records has been provided based on the submitted records which would overturn the previous denials. The records indicate a duplicate request for previously approved X. X is not medically

necessary and non certified

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

The requested X is not medically necessary. No new information or requested URA/Medical records has been provided based on the submitted records which would overturn the previous denials. The records indicate a duplicate request for previously approved X . X is not medically necessary and non certified
Upheld

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 UM KNOWLEDGEBASE

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL