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Notice of Independent Review Decision
Amendment X

IRO REVIEWER REPORT

Date: 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 Overtuned (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. X left hand got X. The diagnoses were injury of ulnar nerve at wrist / hand of left arm and displacement fracture of one ulna styloid process, subsequent for closed fracture with non-union. X was seen by X, MD on X for a follow-up visit of left wrist injury. X was originally evaluated and treated by Dr. X, MD at X and then started been evaluated here in office. Then. X was referred to Dr. X. MD, here in same office, since X started with ulna nerve problems and Dr. X wanted Dr. X to evaluate and treat that. X reported intermitted pain and rated X in terms of intensity that worsened at night. The pain was present on wrist. It was associated with soreness, stiffness, weakness, ulnar side tense, swelling, and numbness on ulnar side. X was able to put left long finger and ring finger more together than before, since X was unable to do so at all. On examination, left ulnar aspect was involved. There was pain with movement and on palpation. There was tenderness, sensation to light touch intact, and two point discrimination was intact. The left wrist had X. There was swelling, bony abnormality, pain with movement and on palpation, and sensation to light touch was intact. Grip strength on the right was X pounds and on the left was X pounds. An electromyography (EMG) studies done on X revealed there was evidence of X. The problem appeared to be over the X. There was X. There were X. There was no evidence of X. The assessment included injury of ulnar nerve at wrist / hand of left arm, initial encounter and displacement fracture of one ulna styloid pro, subsequent for close fracture with nonunion. As per X nerve injury, the surgical treatment was recommended since X had weakness, numbness, and tenderness and an X. An MRI of the left hand dated X showed visualized X. Per the peer review dated X by X, MD, the request for X was denied. Rationale: “Based on the provided documentation, the injured worker is a X who was injured on X and was diagnosed with injury of ulnar nerve at wrist / hand of left arm, initial; displaced fracture of the left ulna styloid pro, subs for closed fracture with nonunion. NCV/EMG study dated on X, revealed there is evidence of X. The problem appears to X: there is X. X-Rays Left Wrist/Hand, 4 views, X dated on X revealed as per X-Rays and X. MRI Left Hand without Contrast dated on X, revealed X. On X, the injured worker presented to Dr. X with left wrist pain. Physical examination revealed left hand: pain with

movement pain with palpation. tenderness. + sensation to light touch intact X point discrimination intact Jell wrist ulnar aspect involved swelling, bony abnormality, X with movement, pain in palpation, sensation to light touch intact. In this case, the provider requested for X. However, the undated X-ray report of the left wrist that shows displaced ulnar styloid fracture nonunion was not submitted for review. Additionally, X-rays left wrist / hand, 4 views, X dated on X, revealed as per X-rays and X. Criteria have not been met. Additional information is needed in order to ascertain the necessity of this request. Therefore, medical necessity has not been established. "Per the peer review dated X by X, MD, the request for X was denied. Rationale: "The appeal request for X. X is not medically necessary. In this case, no x-ray documentation of the nonunion is provided in order to justify this surgical procedure. Therefore, the appeal request for X is not medically necessary. "The requested X is not medically necessary. The submitted imaging reports do not demonstrate the presence of a X. In addition, imaging reports do not support the requested X. As such, no new information has been provided which would overturn the previous denials. The prospective request for 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. The submitted imaging reports do not demonstrate the presence of a X. In addition, imaging reports do not support the requested X. As such, no new information has been provided which would overturn the previous denials. The prospective request for 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**

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

☐ **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**

☐ **PRESLEY 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 (PROVIDE A DESCRIPTION)**