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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 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. X worked for X and did a lot of X. X stated that since X had a lot of pain and X. X did not recall a specific trauma or injury but recalled that back in X had to modify X work due to the pain and symptoms X was having in X hands. X felt like X got a lot of swelling when X overused them The diagnosis included bilateral wrist pain, bilateral carpal tunnel syndrome, flexor tenosynovitis of left wrist, physical deconditioning, disorder of soft tissue of upper limb and neck pain. On X, X was seen by X, MD / X, PA for bilateral wrist pain. X reported hand / wrist pain located on left side on the front and on right side. Pain was described as sharp, throbbing, numbness, tingling and stabbing. Pain was rated X that day. Pain was alleviated by X. Pain was aggravated by lifting, twisting, lying down, pushing / pulling and overhead motion and reaching. Associated symptoms included swelling / redness, buckling, stiffness, numbness, tingling and weakness. X worked for X and did a lot of X. X stated that since X had a lot of pain and X. X did not recall a specific trauma or injury but recalled that back in X had to modify X work due to the pain and symptoms X was having in X hands. X felt like X got a lot of swelling when X overused them. Examination of both hands revealed no significant swelling. X had positive X and X. The X. There was X. X examination was X. X was X. A X was administered into the X. X tolerated the X well. X was recommended to further evaluate X for compressive neuropathy. X was recommended to X. X were recommended. On X, X had a follow up with Dr. X / X for bilateral carpal tunnel syndrome. X had numbness and tingling with activity such as

pinching, pushing, and pulling, as well as nighttime when X tried to sleep. X had injections in X carpal tunnels at X first visit on X. X found those to be moderately helpful for at least a few weeks. An X was ordered, which was denied by Dr. X, who worked for X, with the reasoning that X had not had X. That seemed fairly unreasonable. X were obtained that day. X did not have neck pain. Examination revealed that X. X was X. X had a X. There was X. X were X. The tendons were all functional with X. A X was X. Referral to occupational therapy was given. X-rays of the cervical spine dated X showed X. Mild disc height loss was noted at X. X was seen. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Official Disability Guidelines recommends X. On X, the claimant with bilateral hand/wrist pain rated X described as sharp, throbbing, numbness, tingling, stabbing; claimant feels gets a lot of swelling when overusing hands. Exam shows X. Request is not supported due to upper X would be premature without X. As such, the request for X is non-certified. "Per a reconsideration review adverse determination letter dated X by X, DO, the request for X was non-certified. Rationale: "The Official Disability Guidelines conditionally recommended X based on the criteria for medical necessity. The guidelines would support the proceeding of X. In this case, the claimant complained of bilateral carpal tunnel syndrome. The claimant has had numbness and tingling with activity such as pinching, pushing, and pulling, as well as nighttime when they tried to sleep. Examination showed X. The claimant was X. There was X. X were X. The X were X. X-rays of the neck show a little bit of X. There was some X. Per evidenced-based guidelines, carpal tunnel syndrome should be proved by positive findings on clinical examination and may be supported by nerve conduction tests before surgery is undertaken. However, the medical record does not show evidence of planned surgical intervention. As such, the request of X, is noncertified. "Thoroughly reviewed provided records including imaging findings and peer reviews. Patient with X. While the patient may have carpal tunnel

syndrome, the provider is concerned about other potential neuropathies as well. The patient also had X. Based on the cited guidelines, request X is indicated. X is medically necessary and certified

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

Thoroughly reviewed provided records including imaging findings and peer reviews. Patient with X. While the patient may have carpal tunnel syndrome, the provider is concerned about other potential neuropathies as well. The patient also had X. Based on the cited guidelines, request X is indicated. X is medically necessary and certified

Overturned

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