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IRO Certificate No: X

Notice of Workers' Compensation Independent Review Decision

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
X.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X.

PATIENT CLINICAL HISTORY [SUMMARY]:
This case involves a X with a date of injury on X. The mechanism of injury was a X. The patient was reported X. The diagnosis is listed as left wrist persistent distal radial joint ulnar instability with TFCC tear. The comorbidities are X.

On X, the patient presented for follow-up of X left wrist injury X sustained while at work on X. The patient was last seen in X in which surgery was recommended but the procedure request was denied. X reported X developed X. The patient endorsed pain on the ulnar side of X left wrist, which is worse with gripping, grasping, and twisting and consistent since X injury. The patient reported an MRI was previously performed which suggested a X. The provider stated that the X identified was a coincidental finding and not the cause of X pain. On focused left wrist examination,

the patient was noted with X. X-ray performed during the visit showed X. In the overall impression, the patient was reported with X. X was planned.

On X, a Second Opinion of MRI of the left wrist dated X was completed. In the impression, the findings were X. They further explained that the MRI findings are (based on reasonable medical probability) degenerative in nature. There is no MRI evidence of aggravation (new structural change) of preexisting (degenerative) conditions. There is no finding on the MRI (based on reasonable medical probability) to suggest a post traumatic process related to the DOI.

On X, a Reconsideration Adverse Determination notice was issued. The letter indicated that the request for reconsideration for X is noncertified. The Plan stated that there is X. The Plan noted that given the lack of these information, the patient's condition does not support the requested X.

The provider requested X.

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

The Official Disability Guidelines conditionally recommend X.

In this case, the patient suffered a work-related injury on X. X had a X. In the most recent office visit follow-up on X, the patient complained of persistent left wrist pain which is worse with gripping, grasping, and twisting. X was previously seen in X in which X was recommended but was denied by worker's compensation. X did not pursue X. MRI performed on X had a second opinion on X in which the evaluator noted that the X X-ray during the recent visit revealed X. The provider's overall impression include X. X was planned.

The requested procedure, X, does not meet the cited guideline as the records provided for review do not show evidence of a X. As such, the request for X is considered not medically necessary.

SOURCE OF REVIEW CRITERIA:

- ☐ 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
- ☐ 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)

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