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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: 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

1. X.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case concerns a X who has requested authorization and coverage for X. The Carrier denied this request on the basis that this device are not medically necessary for treatment of the member's condition.

A review of the record indicates that the member has a history of a X. The report from the member's X visit to X treating physician indicated that magnetic resonance imaging showed a nondisplaced scaphoid fracture. It also indicated that the examination revealed tenderness to palpation at the anatomic snuffbox. It noted that x-rays showed a nondisplaced fracture of the scaphoid. It also noted that the treatment plan included a thumb spica splint.

The record from the member's X visit to X treating physician indicated that X reported X. It also indicated that there was some numbness in the member's fingers bilaterally and that examination revealed discomfort in the right wrist with motion

and tenderness to the snuffbox. It noted that x-rays showed healing of the scaphoid fracture. It also noted that the treatment plan was to X.

The record from the member's X follow-up visit to X treating provider indicated that X had sustained a X. It also indicated that the examination revealed some discomfort of the right wrist with motion, some tenderness of the snuffbox and some grip weakness. It noted that the X.

A letter of medical necessity dated X explained that the member had risk factors of non-union, former smoking/nicotine use, obesity, a X. It noted that the length of need for the requested device would be X.

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

The Maximus physician consultant explained that as per ODG, "X are not recommended for any of the following: X". This member was being treated for X. The member presented on X having X. The Maximus physician consultant indicated that the examinations documented in the available records revealed some discomfort of the right wrist with motion, some tenderness of the snuffbox to the right wrist was noted, and overall, some grip weakness noted.

The Maximus physician consultant indicated that however, formal serial radiographs are not provided demonstrating the noted scaphoid fracture is failing to heal. The Maximus

physician consultant also indicated that x-rays on X noted showed X. The Maximus physician consultant explained that additional, ODG does not recommend X. The Maximus physician consultant indicated that no compelling rationale is presented or extenuating circumstances noted in the information provided for review to support the medical necessity of this request as an exception to guidelines.

Therefore, the requested prospective request for X is not medically necessary for the treatment of the member's condition.

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