Envoy Medical Systems, LP **PH: (512) 705-4647**
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Austin, TX 78758 **IRO Certificate #X**

Notice of Independent Review Decision

DATE OF REVIEW: X

IRO CASE NO. 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)**	**X**
Overturned	(Disagree)	
Partially Overturned	(Agree in part/Disagree in part)	

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Initial Denial & Peer Review, X UR Dept/X, MD, X, X
Appeal Reply & Peer Review, X UR Dept/X, MD, X, X
IRO requesting X, X

ODG: *“MCG (web) X” (X)*
Progress/Encounter Notes (13), Texas Workers Compensation Reports): X, PLCC, X, MD,/X, FNP; Dates: X, X

PATIENT CLINICAL HISTORY SUMMARY

This is a X who sustained a work related in X when X was injured while X was X. X had bleeding from the right thumb. X had xrays, a tetanus shot, and sutures to the right thumb. Initial diagnosis was crush injury to the right hand and wrist and fracture of the distal phalanx. MRI of the right wrist and hand were obtained on X and showed X. Patient was evaluated on X complaining of right wrist and hand pain. X requested second opinion. Exam showed X. Tenderness to palpation of the right thumb, metacarpals with decreased range of motion of the thumb. Tenderness of the radial aspect of the wrist and weakness of the right grip and wrist strength and decreased sensation in the right fingers. X was recommended. This was denied due to “no significant change in the patient's condition or clinical deterioration” and lack of X. On appeal, the X. Dr. X recommended waiting to see the results of the X.

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

Opinion: X.
Rationale: This review pertains to the need for X. The numbness and weakness may actually be an indication for X, but would agree with recommendation to wait for the X**.**

The requested service, DX: X, is not necessary at this time.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL

LITERATURE (PROVIDE DESCRIPTION)

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