

P-IRO Inc.
An Independent Review Organization
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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

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured at work on X. X worked for the X. X reported that a X. The diagnoses were sprain of metacarpophalangeal joint of right thumb, initial encounter and traumatic rupture of unspecified ulnar collateral ligament, initial encounter.

On X, X was seen by X, MD for evaluation of right thumb pain. X had an X. It was X in severity. X had been seen X. X had been in a X. There was a popping sensation in X thumb from time to time as well. X likely had a pretty significant injury to X thumb. X had X. X had got a little bit of X. On examination, weight was 327 pounds, and body mass index (BMI) was 56.1 kg/m². On examination X right thumb showed X. X had about a X-degree arc of motion of the X. X had X. X had more X. X had zero (X) to X degrees of motion. Minimal tenderness was noted at the X. X-rays of the right thumb that day revealed X. X was seen on a lateral view. MRI from X, was reviewed, showing the X. Treatment plan was to proceed with X.

An MRI of the right hand dated X revealed X. There was X. Reactive first X was seen.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, and a peer review dated X, the request for X was denied by X, MD. Rationale: "ODG by MCG Last review/update date: X X: X "Conditionally recommended as described in the ODG Criteria. ODG Criteria X" Per the office visit note from X, the patient has a diagnosis of a disruption to the radial collateral ligament and a disruption of the

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ulnar collateral ligament. The request is for a X. However, the magnetic resonance imaging (MRI) report was not provided for review, which is a requirement of medical treatment guidelines. Therefore, the request for X is not medically necessary. Therefore, the request for X is non-certified.”

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “Per ODG by MCG, X. ” This is a X year-old claimant with right thumb pain rated at X with swelling, popping, and locking. Physical examination reveals swelling at the X, a X-degree arc of motion of the X. There is X. Radiographs of the right thumb dated X disclose X. MRI of the right thumb dated X demonstrates disruption of X. Guidelines support X. Although the physicians note references and interprets the MRI as showing X, no formal MRI report was provided in the medical records for review. This documentation would need to be submitted before the request could be considered. Additionally, there is no documented appeal letter from the provider. Furthermore, guideline criteria have not been met. Therefore, the request for X is not certified.”

This is a X- year-old claimant with right thumb pain rated at X with swelling, popping, and locking. Physical examination reveals swelling at the X, a X-degree arc of motion of the X. There is X. Radiographs of the right thumb dated X disclose X. MRI of the right thumb dated X demonstrates X. Guidelines support X. Although the physicians note references and interprets the MRI as showing X, no formal MRI report was provided in the medical records for review. This documentation would need to be submitted before the request could be considered. Additionally, there is no documented appeal letter from the provider. Furthermore, guideline criteria have not been met. No new information has been provided to overturn the previous denials. 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:

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This is a X- year-old claimant with right thumb pain rated at X with swelling, popping, and locking. Physical examination reveals X. There is X. Radiographs of the right thumb dated X disclose X. MRI of the right thumb dated X demonstrates X. Guidelines support X. Although the physicians note references and interprets the MRI as showing disruption of X, no formal MRI report was provided in the medical records for review. This documentation would need to be submitted before the request could be considered. Additionally, there is no documented appeal letter from the provider. Furthermore, guideline criteria have not been met. No new information has been provided to overturn the previous denials. X is not medically necessary and non-certified.

Non-Certified.

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

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- TMF SCREENING CRITERIA MANUAL
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- MILLIMAN CARE GUIDELINES
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

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- INTERQUAL CRITERIA
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE