I-Resolutions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 IR
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 790-2280
Email: @i-resolutions.com

Notice of Independent Review Decision
Amendment X

IRO REVIEWER REPORT

Date: X; Amendment 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 Overtuned (Agree in part/Disagree in part)

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X sustained injuries to right thumb in the normal course and scope of X employment while working with a X. X had first noticed X complaints in X that progressed to the point of keeping X awake at night. X complaints worsened with repetitive use of a X. X reported X injury on X when X was unable to pinch a razor blade to cut material. The diagnosis was radial styloid tenosynovitis (de Quervain) (X). X was seen by X, MD on X for a complaint of persistent right elbow pain. X was status post right de Quervain's release on X. X had persistent right anterior elbow and proximal forearm pain. It increased with use and decreased with rest. Sometimes, the pain would radiate into X ring finger. There was no locking or popping of X ring finger. X stated it was hard for X to lift and do X job. X was refused. On examination, the right elbow had excellent range of motion. X had mild tenderness to palpation over the biceps. X had slight pain with resisted supination with X elbow flexed X degrees. X had moderate tenderness to palpation over the radial tunnel but negative long finger extension test. X right ring finger had full range of motion with no tenderness at the A1 pulley. An X was recommended. An X progress note was documented on X by X, OT. X reported difficulty with gripping, difficulty writing, pain with activities of daily living and pain with repetitive pinch. X underwent right first dorsal extensor compartment release on X. X reported increased pain, shooting up the forearm and sensitivity to pronator muscle of the forearm. X had severe pain in the forearm. X had significant pain at proximal forearm. There was tenderness to palpation with hardened muscle tissue. The rehabilitation potential was fair. X was able to perform activities with difficulty due to pain. X progress towards goals was fair and X tolerance to treatment was fair. Treatment modalities included X. This was visit number X. X was to be continued for X. A maximum medical improvement and impairment rating evaluation was performed by X, DC on X. X was X. It was believed that X injuries had not reached a position that was stable. Further medical intervention was expected to improve X condition or change X percentage of impairment, thus, X had not obtained maximum medical improvement. The expected date of maximum medical improvement was X. This date was chosen based on an indication in the medical record of continued expectation of further functional gains anticipated with treatment recommended by ODG specifically X. ODG recommended up to X postoperatively for radial styloid tenosynovitis. Based on clinical examination, recent surgery, sensory testing, review of available documentation and ODG, it was determined that X had not obtained maximum

medical improvement, and anticipated date of maximum medical improvement was X. Treatment to date included X. Per a notice of adverse determination letter dated X, the request for X was non-certified. Per a Peer Review Report dated X by X, MD, the request for X was not medically necessary. Rationale: "Based on the documentation provided, the official disability guidelines (ODG) Forearm, Wrist, and Hand (updated X)-Online Version, X, is not satisfied. In particular, the requested X exceeds guidelines. Thus, the request is not certified. Therefore, X is not medically necessary. "Per a notice of adverse determination letter dated X, the request for appeal X was upheld. Per a peer review report dated X by X, MD, the request for appeal X was not medically necessary. Rationale: "The claimant is status post X. Previous treatment includes X. The request is for an X which exceed guideline recommendations. Per ODG, Synovitis or tenosynovitis: Medical treatment: X: X. A modification of the request to X would be reasonable and supported by medical treatment guidelines. However, modification of the requested service is not allowed in the state of Texas without approval from the treating provider. Therefore, the APPEAL X is not medically necessary. "The requested X is not medically necessary. The records reflect that the claimant underwent a X. The records reflect that the claimant attended X. The number of X being requested exceeds the recommended guidelines and evidence-based medicine. The records do not reflect any type of extenuating circumstances which would supersede the recommended guidelines. No new information has been provided which would 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:

The requested X is not medically necessary. The records reflect that the claimant underwent a X. The records reflect that the claimant attended X. The number of X being requested exceeds the recommended guidelines and evidence-based medicine. The records do not reflect any type of extenuating circumstances which would supersede the recommended guidelines. No new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified Upheld

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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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**
- ☐ **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)**