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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. The mechanism of injury was described as a X. X was working as a X. X was X, and X finger was X. The diagnosis was partial traumatic transphalangeal amputation of right middle finger, initial encounter (X). X was seen by X, DC on X for evaluation of ongoing symptoms. X continued to have issues with medications. X stated that the pain was much better with medications, but X still had a lot of anxiety when taking medications. X stated X could get a sharp electric-like pain that happened randomly. X noted weakness in X arms and hands. X could hold X pounds for more than X seconds. X stated that when the doctor took the tissue of the graft, X felt like something happened. X stated X could shake someone's hand, but X could not carry X groceries. X felt like X was disabled. X sustained a work-related injury on X. X finger was X. Following the injury, X was taken to the emergency room. X was told that X would need a X. X had undergone X on X, and X on X. X did some X. On examination, there was X. X was noted in the X. There was X. X was noted. There was X. X was X. It was documented that a more extensive evaluation would need to be done by a hand and wrist specialist. The assessment included X. A referral for X was provided for X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "The ODG recommends X. In this case, the records indicate that the individual has previously X. However, there was no documentation regarding the X. Further, there has been no documented re-evaluation on X. Given these facts, the request for X is non-certified. Per a reconsideration review adverse determination letter dated X, the prior denial was upheld by X, DC. Rationale: This request was previously noncertified due to no documentation of X. The physician sent an appeal without new information. Based on claim information, the claimant has X on X. The ODG recommends X. The claimant had a X. The assessment showed X. This request was previously noncertified due to X. The physician sent an appeal without new information. Based on claim information, the claimant has X. Due to X, exceeding the guideline's recommendation and no objective improvements, the request is not recommended. Thus, the appeal request for is noncertified. Peer to peer was unsuccessful. "Based on the clinical

information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "The ODG recommends X. In this case, the records indicate that the individual has X. However, there was no documentation regarding the X. Further, there has been no documented re-evaluation on X. Given these facts, the request for X is non-certified. "Per a reconsideration review adverse determination letter dated X, the prior denial was upheld by X, DC. Rationale: This request was previously noncertified due to X. The physician sent an appeal without new information. Based on claim information, the claimant has X. The ODG recommends X. The claimant had a X. The assessment showed decreased X. The physician recommended X. This request was previously noncertified due to X. The physician sent an appeal without new information. Based on claim information, the claimant has X. Due to X, exceeding the guideline's recommendation and X, the request is not recommended. Thus, the appeal request for X is noncertified. Peer to peer was unsuccessful." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is no information provided X. There are no X. The patient reportedly underwent X. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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:

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "The ODG recommends X. In this case, the records indicate that the individual has X. However, there was no documentation regarding the X. Further, there has been no documented re-evaluation on X. Given these facts, the request for X is non-certified. "Per a reconsideration review adverse determination letter dated X, the prior denial was upheld by X, DC. Rationale: This request was previously noncertified due to X. The physician sent an appeal without new information. Based on claim information, the claimant has X. The ODG recommends X. The claimant had a X. The assessment

showed X. The physician recommended X. This request was previously noncertified due to X. The physician sent an appeal without new information. Based on claim information, the claimant has X. Due to X, exceeding the guideline's recommendation and no objective improvements, the request is not recommended. Thus, the appeal request for X is noncertified. Peer to peer was unsuccessful." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is no information X. There are X. The patient reportedly underwent X. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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)**