po box 519
schertz, tx 78154
p: 800.292.3051
f: 888.972.7053

IRO Certificate No:

Notice of Workers' Compensation Independent Review Decision

Date of Notice: X

Date Amended: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]: This is a case of a X who had an injury on X while working on a X.

A Standard Written Order was provided on X for the claimant with a diagnosis of Partial traumatic transphalangeal amputation of left index finger, subsequent encounter, and Partial traumatic transphalangeal amputation of left middle finger, subsequent encounter. It was noted that the claimant presented with a left partial amputation. Sensitivity and reduced grasping capability limit X function in daily living and vocational activities. A X will provide active function in heavy-duty work and activities of daily living (ADLs). Restoring X will prevent complications due to awkward positioning of the affected hand and overuse of the contralateral hand.

According to the Request for Authorization, the claimant X. Functional deficits include X. The X that allows the X. The X will also X. Due to X. In addition to assure the most appropriate cleaning and alignment of X, a X. This allows for X. Eating at bedside alone will let me information for assessment for X. The recommended X were expected with increased function of X.

A denial letter was issued on X for the request for X.

A peer-to-peer call was attempted on X, and at X, however it was unsuccessful.

According to the appeal letter dated X, a X that would provide appropriate function increase daily living and work activities. Dislocation was the primary reason for the X. At the time of X injury, the claimant worked in X. While X has returned to work X has been put on light duty status. Without X, X will not be able to perform the necessary task required.

On X, a denial letter was issued for the appeal request and it was determined that the denial was upheld. A peer-to-peer call was attempted on X and X but were unsuccessful.

According to the request for independent review dated X, the claimant has a X. A X will provide appropriate function in X daily living and work activities. The X.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
This is a case of a X who had an injury on X while X. The claimant worked in X. X has a diagnosis of Partial traumatic transphalangeal amputation of left index finger, subsequent encounter, and Partial traumatic transphalangeal amputation of left middle finger, subsequent encounter. It was noted that the claimant presented with a X. Sensitivity and reduced grasping capability limit X function in daily living and vocational activities. A X. Restoring X will prevent complications due to X.

According to the Official Disability Guidelines, X
Patient is motivated to X.

Upon review of all the information provided, the claimant X. The X has resulted to impaired grip, strength, dexterity, and fine motor coordination which has impacted X independence and safety with daily activities. The X was recommended as X. Furthermore, X was also being seen X
Therefore, meeting the criteria of the Official Disability Guidelines, X. As such, the requested X are the most appropriate X and are medically necessary for this patient. Therefore, the denial is overturned.

SOURCE OF REVIEW CRITERIA:

☐ 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 Judgment, Clinical Experience, and Expertise in Accordance with Accepted Medical Standards
☐ Mercy Center Consensus Conference Guidelines
☐ Milliman Care Guidelines
☒ ODG- Official Disability Guidelines & Treatment 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)

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

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
X