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[Date notice sent to all parties]:

01/27/2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX/XX for the XX XX extremity

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
DO, Board Certified Neurosurgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X 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.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XX year old XX whose date of injury is XX. The patient was trying XX in the XX XX extremity at the XX. XX/XX dated XX notes the patient is status post XX-XX XX about XX years prior. The patient has a past history of XX sided XX XX XX and XX surgeries on the XX XX approximately XX years prior. There is no electrical evidence for a XX XX. There is electrical evidence for a XX median XX XX across the XX. XX XX XX. The XX severity is moderate. There is electrodiagnostic evidence for a XX sided XX XX XX across the XX. There is electrical evidence for a XX sided XX XX across the XX. According to Office Visit dated XX, the patient complained of XX XX pain. On examination, the patient appeared pleasant and no acute distress. The patient was well nourished, well developed who appeared to be of XX XX. There was no XX. The XX had no

exudate. The XX XX. The XX was supple with no XX and no XX. There were no XX, no XX, and no XX on the extremities. The patient's XX XX were 2 plus XX. The XX was warm and moist without XX, visible XX, XX, dryness, and XX. The XX was normal in color. The patient's XX was XX. There was intact XX and XX. The patient was alert and oriented. The patient's XX and XX was within normal variation. The XX were normal to confrontation testing. The patient's XX were XX. There was normal XX movements and XX. There was normal XX XX and ability to XX XX. There was XX movement of the XX and XX with tight closure of the XX. The XX was normal. The XX rose normally with XX and XX. The patient was able to raise XX and turn XX to midline against resistance. The XX protruded in midline and no XX. XX XX test was XX/5 XX. There were normal XX XX and XX extremities to light XX, XX and XX. There was positive XX XX sign. The patient's reflexes were XX XX. The XX were down-going XX. The patient's XX and XX were absent. The XX coordination was intact. There was no XX. The patient's XX and station were within normal limits. The patient had an XX (undated) which documented XX XX XX and median XX XX across the XX. Treatment plan included to obtain repeat XX and XX conduction studies of both XX extremities to evaluate for XX and XX. The provider advised referral to XX to evaluate XX XX pain and XX XX XX, and to follow up in XX month. The patient was diagnosed with 1) unspecified sprain of XX XX, 2) XX, XX region, 3) XX of XX, and 4) XX in diseases classified elsewhere. Initial request for XX/XX for the XX XX extremities was non-certified noting that the previous XX/XX is not provided for review and is not discussed in the records provided. There is no report that the previous test was not done correctly or was inadequate. Repeat testing is not certified unless there is an explanation of the previous test. Also, XX of XX XX extremities is not medically necessary because the XX side is XX. Appeal letter dated XX indicates that the patient presented with XX XX pain and XX in XX XX. Neurological examination with positive XX on the XX. Possible XX. Prior XX reportedly shows possible XX XX XX XX and XX median XX at the XX. These results are reportedly unclear and do not explain XX symptoms. The denial was upheld on appeal noting that there is no clinical rationale for a repeat study. This request exceeds guidelines. Information submitted is insufficient.

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 XX/XX for the XX XX extremity is not recommended as medically necessary, and the previous denials are upheld. Initial request for XX/XX for the XX XX extremities was non-certified noting that the previous XX/XX is not provided for review and is not discussed in the records provided. There is no report that the previous test was not done correctly or was inadequate. Repeat testing is not certified unless there is an explanation of the previous test. Also, XX of XX XX extremities is not medically necessary because the XX side is XX. The denial was upheld on appeal noting that there is no clinical rationale for a repeat study. This request exceeds guidelines. Information submitted is insufficient. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient underwent

prior XX/XX study on XX, less than XX XX ago. The submitted clinical records fail to establish that the prior study was performed incorrectly. There is no documentation of a significant change in clinical presentation to support another study at this time. Additionally, there is no clear rationale provided to support XX/XX for the XX XX extremity when the patient's injury was to the XX XX extremity. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES