IRO Express Inc.

Notice of Independent Review Decision

IRO Express Inc.
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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 on X. The mechanism of injury was not documented in the provided medical records. X sustained a X. The diagnosis was pain in right wrist; orthopedic aftercare; and other mechanical complication of other internal orthopedic devices, implants, and grafts.

On X, X was evaluated by X, MD, for a follow up evaluation status post X. X was with a history of X. At X previous visit, X reported continued X. X options were discussed, and due to X, X chose to X, but the surgery was denied by insurance. Pain scale was X, and X was not taking anything for pain control. At the time, X was not X. On examination, the right upper extremity incision was clean, dry, and intact with no drainage, warmth, or erythema. There was X edema noted to the fingers. Wrist range of motion was limited due to pain. There was tenderness to palpation over the X. Grip strength was X. X was positive. Sensation was intact to light touch (X) "X." X was neurovascularly intact distally. The fingers were warm and well perfused. X-rays of the right wrist were ordered. X-rays of the right forearm obtained that day were reviewed and demonstrated X. The assessment was pain in X. It was noted that X was doing well but with a dissatisfactory postoperative course. Healing and recovery expectations were discussed. X was with continued wrist pain; Dr. X explained this could be secondary to the rest of X. The remaining X

was causing hypersensitivity to palpation and mechanical block that had not improved with previous conservative treatments. They discussed in detail, the risks and benefits of surgical versus nonsurgical treatment options. Nonsurgical treatment would be continued observation. Surgical treatment would be X. X understood X options and chose to proceed with X. All patients questions and concerns were answered. X would follow up X.

X-rays of the right forearm obtained on X were reviewed and demonstrated X.

Treatment to date included X, X,

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD, as not medically necessary. Rationale: "X, ODG states that X. Following fracture healing, improvements in pain relief and function can be expected after X. In this case, the claimant is X. Due to persistent pain, limited wrist range of motion and grip strength as well as specific complaints of X pain occurring when resting the hand on a surface, the provider recommended X. This was performed on X. The provider noted some improvement in postoperative wrist range at the X visit, but pain remains high. It should be noted that the claimant also reports numbness in the wrist as well as pain in the shoulder and pain on the side of the arm. There is no specific localized pain reported at the site of the X. There is no specific tenderness at this location on exam. Given this and as the documentation does not provide additional support for confirmation of this as a source of X. Therefore, this request is not medically necessary. Denial is recommended."

An undated appeal letter by Dr. X was documented. Dr. X wrote to formally appeal the denial of the claim for X for X patient, X who had been experiencing persistent pain (X) in excess of X months in X. X had also demonstrated reduced grip strength (X) and limited range of motion in the affected wrist. These symptoms were severely impacting X daily function and quality of life. While recent x-rays showed that the X, X ongoing symptoms were likely related to X. Additionally, X previously underwent X. While an X could be considered, it was not an applicable solution to the underlying problem as it would only provide temporary resolution while increasing likelihood of infection, damage to nerves, tendons, and vessels. Additionally, while X, exhibited a history of shoulder pain, these conditions could occur separate of one another. X exhibited no history of radiating pain, cervical pain that might indicate the shoulder was a conjoined issue to the wrist. The proposed surgery to remove the X was necessary for symptom relief and improved function. After a thorough discussion of both surgical and nonsurgical options, X had opted for surgery to address X persistent pain and dysfunction.

Per a reconsideration review adverse determination letter dated X, the appeal request for X was noncertified as not medically necessary by X, MD. Rationale: “This is an appeal of a previous denial for X. The ODG does not recommend X. The provided appeal letter stated that the claimant’s ongoing symptoms were likely due to X. However, there is no clear evidence that the claimant’s X. X were not documented. Imaging found X. There is no indication of any X. Given these issues which do not meet guideline recommendations, I cannot recommend certification for this request.

Based on the submitted records, the requested X is not medically necessary. The imaging reports do not demonstrate X. A diagnostic X has

not been provided to determine if the X. 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:

Based on the submitted records, the requested X is not medically necessary. The imaging reports X. A diagnostic X. No new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified.

Upheld

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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

☐ 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