Clear Resolutions Inc.
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Notice of Independent Review Decision

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:
Orthopedic Surgeon

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)

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☒ 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.

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who reported right elbow pain and numbness since X. The mechanism of injury is described as prolonged activities of typing required for X job. The diagnosis was lateral epicondylitis, right elbow; carpal tunnel syndrome, right upper limb; and localized swelling, mass, and lump, left upper limb. On X, X was seen by X, MD, for follow-up of X ongoing complaints. X presented X months status X, dated X. X had difficulty getting into X. X persisted with some residual stiffness of the right elbow due to lack of therapy. X stated that X symptoms of numbness and tingling had resolved post-surgical intervention. Physical examination revealed X was well appearing, in no distress. On examination of the right elbow, range of motion revealed active range of motion was X degrees of flexion, passive was full; X lacked X degrees of extension, was stable to varus and valgus stress. X would be sent a new prescription for therapy to work on range of motion exercises for X right elbow. X was advised to X. Regarding work status, X may return to work on X with the following restrictions until the next examination in X weeks: weightlifting restrictions X pounds; no pushing, pulling, or lifting with the affected upper extremity greater than the specified amount. Treatment to date included X. Per a utilization review adverse determination letter dated X, and a peer review report by X, MD, dated X, the request for X, was non-certified. Rationale: “Per Official Disability Guidelines, Physical/Occupational Therapy (PT/OT) for Pain, "Recommended for X. Allow for X. Treatment should be "active", with formal re-assessment after a "X-visit clinical trial" to evaluate whether therapy has resulted in positive, negative, or no impact, prior to continuing or modifying treatment." Per Official Disability Guidelines,

Elbow (X), X, "Recommended (generally) Recommended. Limited evidence. ODG Criteria ODG X. Further trial visits with fading frequency up to X. X: Post-surgical treatment: X." In this case, the claimant reported difficulty getting into X. The claimant had X. The right elbow showed range of motion was lacking X degrees of extension. Per case discussion, the medical assistant stated that the claimant had X. Also, there is no need identified for X. The request is not shown to be medically necessary. Therefore, this request is not certified. “Per a peer review report by X, MD, dated X, the requested services of X was not medically necessary. Rationale: “Based on the provided documentation, the claimant has right elbow pain. The physical examination of the right elbow revealed decreased range of motion. Residual stiffness is noted throughout. Per ODG guidelines, "post-surgical treatment: X." The claimant is X. They have X. Texas justification does not allow for modifications without attending providers permission. Thus, the request is not certified. Therefore, the X is not medically necessary. “Per a reconsideration review adverse determination letter dated X, the appeal request for X, was denied. The prior determination was unchanged and appeal was upheld by physician advisor. Sedgwick wrote, “X. No other condition naturally resulted from or was affected by the original incident. All other conditions, diagnoses, and / or symptoms related to the injured body part, or any other part of the claimant’s body are denied as not resulting from the accident. “Based on the submitted documentation, the requested X is not medically necessary. The records reflect that the patient has already X. The number of sessions completed already exceeds the recommended guidelines. No new information has been provided which would overturn the previous denials and supersede the recommended guidelines. X is not medically necessary and non-certified

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ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the submitted documentation, the requested X is not medically necessary. The records reflect that the patient has already X. The number of sessions completed already exceeds the recommended guidelines. No new information has been provided which would overturn the previous denials and supersede the recommended guidelines. 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:

- ☐ **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)**