

**Amendment Date: x**

## **Notice of Independent Review Decision Amended**

**x**

**Amended: x**

**IRO Case number: x**

**Description of the services in dispute**

X

**Description of the qualifications for each physician or 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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

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

The claimant is a X diagnosed with unspecified fracture of shaft of right radius, distal radioulnar joint dislocation, range of motion deficit, right hand weakness, right arm pain. The claimant is seeking X.

Occupational Therapy Notes dated X documents the claimant who sustained a right mid-shaft radius fracture and distal radioulnar joint injury during a X. The claimant reports that X was already on the X. Per the occupational therapy notes dated X the claimant states X "has difficulty turning wheel; handwriting, typing; chopping food/cutting food; opening jars; shaking people's hands; X." Additionally, the therapy notes state "X goal for therapy is to regain normal functional use of X right arm (dressing self, feeding self, driving, handwriting) and returning to normal work duties (X.) "

Denial Letter from X dated X states "This correspondence pertains to the review of the following health care service(s). As requested, a second contracted physician who was not involved in the original non-certification has reviewed the original information, supplemented by additional medical records submitted and/or peer discussion(s) with the treating provider. The second physician has upheld our original non-certification. Specific Request: X: Appeal Upheld by Physician Advisor. The above review was made based on guidelines which are developed from acceptable standards of

practice as recommended by medical specialty societies, the latest evidence from published research, federal agencies and guidelines from prominent national bodies and institutions.”

**Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision**

The claimant is a X diagnosed with unspecified fracture of shaft of right radius, distal radioulnar joint dislocation, range of motion deficit, right hand weakness, right arm pain. The claimant is seeking X.

The claimant has a right mid-shaft radius fracture and distal radioulnar joint dislocation, both of which are specifically listed in the ODG guidelines as conditions warranting X. The ODG guidelines support up to X. Therefore, the request for X.

Clinical records indicate that the claimant continues to experience functional impairments, including difficulty with turning a steering wheel, typing, handwriting, opening jars, and performing essential work tasks such as X. These deficits directly affect the claimant’s ability to return to work safely and support the medical necessity of X. The claimant is also participating in X, demonstrating progress, and has yet to reach maximum functional improvement; all of which meet ODG criteria and justify medical necessity in this case.

Therefore, it is the professional opinion of this medical reviewer to overturn the denial of X.

## **Description and source of the screening criteria or other clinical basis used to make the decision**

- ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase
- AHRQ - Agency for Healthcare Research and 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