

**P-IRO Inc.**  
**An Independent Review Organization**  
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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: 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. X stated that X was X. X stated X tried to X. The diagnosis was sprain of joints and ligaments of unspecified parts of neck, and strain of unspecified muscle, fascia, and tendon at shoulder and upper arm level, unspecified arm.

On X, X was evaluated by X, PA-C / X, MD, for routine follow-up following an injury to X left upper extremity at work. Since X prior visit, X reported no resolution in X symptoms. X continued experiencing weakness with gripping objects in the left hand, soreness and pain in the hand, and occasional paresthesias. X reported X felt the most comfortable when X was not moving X hand. Examination revealed X. There was X. The assessment was X. An X was recommended to evaluate for X that had not improved with treatments; this may help localize level for possible X, if needed, and help with prognosis. Given persistent tingling, radiation of pain, and functional limitations, X. X would be continued. X were refilled. A SOAP note dated X, by X, PA-C, was documented. Per the note, X returned for reevaluation of medication. At the prior visit, because of chronic pain and early signs of depression, X was started on X. X took it twice and had a significant adverse reaction both times with severe stomach upset with dizziness and disorientation. On the third day, X discontinued the medication and X symptoms resolved. X injuries interrupted all normal activities; however, X was working X hours a week. On examination, X demonstrated X degrees of cervical flexion and X degrees extension. The assessment was X.

X-rays of the left wrist dated X, revealed X. X-rays of the left elbow dated X, revealed X. X-rays of the left shoulder dated X, revealed X. X-rays of the left hand dated X, showed X. X-rays of the cervical spine dated X, revealed X.

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Treatment to date included X.

In a letter of Pre-Certification Request for X for X, dated X, by X, it was documented, "We request preauthorization for the services listed above, which are medically necessary to diagnose and develop a treatment plan for X. This request is supported by X. a failure to respond to X, and the need to differentiate between competing diagnoses following X work-related trauma. This request is based on referrals from both the treating provider, Dr. X, and the X specialist, Dr. X." "The patient presents with X. A definitive diagnosis is required to guide further treatment, which may include X. The requested X is medically necessary per ODG and Texas DWC guidelines to localize the site of the X. This test is crucial to resolving the diagnostic uncertainty and moving this case forward."

Per a utilization review adverse determination letter dated X, the request for X, was denied by X, MD. Rationale for denial of X: "ODG notes that the X. Reason for testing is X. In this case, the records document a X. Exam reveals diminished X. Thus, considering the presence of X would have been supported as medically necessary for confirmation of diagnosis. As the request for X would have been supported, the medical necessity of X is not established. The request for X is not supported as medically necessary, as documentation does not support a clinical presentation with evidence of concern for X on the right side to consider further assessment with X. As there has been no agreement to a modified treatment plan the request in total is not considered medically necessary." Rationale for denial of X: "ODG notes that the X. Reason for testing is X or more of the following: confirmation of clinical diagnosis, discrepancy between symptoms, physical findings, or imaging tests, documentation of progression or improvement, new symptoms suggesting new diagnosis, and poor response to treatment. In this case, the records document a X. Exam reveals X. The provider notes that the MRI dated X reveals X. Thus, considering the presence of X. The request for X of the right upper extremity is not supported as medically necessary, as documentation does not support a clinical presentation with evidence of X. As there has been no

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agreement to a modified treatment plan, the request in total is not considered medically necessary.”

In an appeal letter dated X, X, MD, wrote to formally appeal the denial of the request for X for X, and documented the following: “This patient has X. X has X. The C-spine MRI confirms a structural issue (X) but cannot explain the functional or atypical nature of X symptoms. Furthermore, the carrier has disputed the relatedness of these MRI findings, calling them "pre-existing." The requested X is the only test that can resolve this diagnostic uncertainty. It will: 1. X. 2. X.”

Per a reconsideration review adverse determination letter dated X, the appeal request for X, was denied by X, MD. Rationale for denial of X: “ ODG notes that the X. Reason for testing is X or more of the following: confirmation of clinical diagnosis, discrepancy between symptoms physical findings, or imaging tests documentation of progression or improvement, new symptoms suggesting new diagnosis and poor response to treatment. In this case, the claimant presents with a X. The claimant reports X. Exam notes X, The provider notes that the claimant has a complex differential diagnosis that requires testing X. The X, Dr. X, specifically ordered this test to "X." The provider also notes that the asymptomatic right arm is not being tested for "concern"; it is being tested to serve as the claimant's own internal control. There is no indication for X. It is not considered medically necessary to perform multiple studies using a range of CPT codes. In addition, there are no complicating factors identified that would support the need for X. A request for X. The provider has not available to discuss a modified treatment plan and therefore the request in full is not considered medically necessary.” Rationale for denial of X: “ODG notes that the X. Reason for testing is X or more of the following: confirmation of clinical diagnosis, discrepancy between symptoms, physical findings, or imaging tests, documentation of progression or improvement, new symptoms suggesting new diagnosis, and poor response to treatment. In this case, the claimant presents with a X, The claimant reports X. Exam notes X, MRI shows X. The provider notes that the asymptomatic right arm is not being tested for "concern"; it is being

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tested to serve as the claimant's own internal control. Given the presence of X, MRI finding of X, and new information provided, an X would have been supported for further diagnostic assessment of the claimant's pain complaints and limitations. There are no identified complicating factors that would warrant the X. Therefore, this request is not medically necessary."

#### **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 X is not recommended as medically necessary and the previous denials are upheld. The initial request was non-certified noting that, "ODG notes that the X. Reason for testing is X or more of the following: confirmation of clinical diagnosis, discrepancy between symptoms, physical findings, or imaging tests, documentation of progression or improvement, new symptoms suggesting new diagnosis, and poor response to treatment. In this case, the records document a complaint of X. Exam reveals X. The provider notes that the MRI dated X reveals X. Thus, considering the presence of X. The request for X is not supported as medically necessary, as documentation does not support a X. As there has been no agreement to a modified treatment plan, the request in total is not considered medically necessary." The denial was upheld on appeal noting that, ""ODG notes that the X. Reason for testing is X or more of the following: confirmation of clinical diagnosis, discrepancy between symptoms, physical findings, or imaging tests, documentation of progression or improvement, new symptoms suggesting new diagnosis, and poor response to treatment. In this case, the claimant presents with a X. Exam notes X. The provider notes that the asymptomatic right arm is not being tested for "concern"; it is being tested to serve as the claimant's own internal control. Given the presence of X, MRI finding of X, and new information provided, an X would have been supported for further diagnostic assessment of the claimant's pain complaints and limitations. There are no identified complicating factors that would warrant the right sided study given the lack of complaints on the right. Therefore, this request is not medically

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necessary.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records indicate that the claimant sustained an injury to the left upper extremity. All findings on physical examination are on the left side. There is no documentation of an injury to the right upper extremity. There are no red flag findings of the right upper extremity on exam to support X. There is no documentation of any treatment performed for the right upper extremity. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. X is not medically necessary and non-certified.

Non-certified.

#### **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

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- 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