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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)

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 [SUMMARY]:

X is a X who was injured on X when X. The diagnosis was other specified sprain of left wrist, subsequent encounter (X); other intraarticular fracture of lower end of left radius, subsequent encounter for closed fracture with routine healing (X); fracture of unspecified carpal bone, right wrist, subsequent encounter for fracture with routine healing (X); other specified postprocedural states (X).

Per a Daily Note dated X, by X, PT, X had no pain at that time. X had X. X stated X had X. X stated X had pain initially at the wrist, but t went away fairly quickly. X stated X had no issues driving. X reported the pain that day at the left wrist was 0/10 at best and the pain at the right wrist that day was 0/10 at best. X reported the pain was located in X left greater than right wrist and described the pain as sore in nature. QuickDASH score completed on X was 48.3. X underwent physical therapy that day. X assessed that X appeared motivated and was able to perform exercises correctly with difficulty but no pain. X progress towards goals was good, and X tolerance to treatment was good. Therapist added fine motor skills for left with picking beans from rice. X showed good tolerance but could not oppose the thumb and fifth digit on either hand even before injury due to the length and width of fingers. X was still tight and sore along the joint line of the left wrist at end-range. X would continue therapy as prescribed. X, MD documented a physical therapy plan of care on X. X presented to therapy. X reported having no pain that day. X really wanted to return to work. X chief complaints included pain, decreased range of motion, and decreased strength and treatment was to focus on these. QuickDASH score on X was 19.16. X was working full-time with restricted duties, stating the surgeon had not released X to work yet. It was assessed that X had improved overall with strength on the right wrist. Range of motion on the right was slightly more limited in some motions, but possibly due to measurements taken prior to stretches. Left wrist range of motion (ROM) was improved in almost all directions. Strength was not tested as X was not cleared by MD for strengthening exercises yet. X had only minimal pain intermittently but had not pushed using X left arm beyond normal daily activities. X was recommended to progress strength and function of left wrist per MD when released to progress. X and / or family were aware of X diagnosis. The plans and goals had been developed and discussed with X. X rehabilitation potential was good. On examination, right wrist active range of motion (AROM) showed 65/65 forearm pronation / forearm supination, 59/54 wrist extension / wrist flexion, 15/15 wrist radial deviation / wrist ulnar deviation. Left wrist AROM showed 60/65 forearm pronation / forearm supination, 45/50 wrist extension / wrist flexion, 15/15 wrist radial deviation / wrist ulnar deviation. X was unable to oppose thumb and fifth finger on either hand but stated X had never been able to do this. Left fifth finger caught and popped with flexion but had full range of motion. On manual muscle testing (MMT), right wrist strength was 5/5 throughout. Left wrist MMT was not tested due to precautions. Grip strength by grip dynamometer 2 was 95 pounds on the right and 55 pounds on the left, by 3 jaw chuck was 21 pounds on the right and 18 pounds on the left, by lateral pinch was 21 pounds bilaterally, and by tip to tip was 21 pounds bilaterally. Posture was observed as forward head and rounded shoulders. There was numbness along the dorsum of the left wrist and numbness / tingling proximal wrist on dorsal surface and at the ring finger metacarpophalangeal (MCP) joint. Tenderness to palpation was noted along the pisiform and ulnar side of wrist on the left, and also along the dorsal wrist at the joint line on the left. Lateral incision was well healed with only mild scar tissue noted. On observation, there was no difficulty with activities of daily living, moderate limitation with grip, severe limitation with lifting, and inability to do work tasks. X was to X. The treatment plan included X. On X, X visited Dr. X postoperatively. X was status post triangular fibrocartilage complex repair performed on X. X was experiencing significant stiffness and limited motion in X left wrist. This condition impacted X ability to perform X duties as a X. X reported that therapy had been somewhat helpful, but X still required more motion to regain strength and endurance. X mentioned that X could not move X wrist when X started therapy, indicating some improvement, but X felt X had plateaued and needed more X to achieve full motion. X was motivated to regain full use of X hand as quickly as possible. X described the pain as being localized to the backside of X wrist, which X attributed to stiffness. X was unsure why this area was particularly painful, but X acknowledged that it might be due to the nature of X work and the physical demands placed on X wrist. X was eager to continue therapy and was willing to perform exercises at home to expedite X recovery. X expressed a desire to achieve full motion, strength, and endurance in X wrist to return to X job without limitations. On musculoskeletal examination, left wrist evaluation revealed range of motion with extension 45

degrees, flexion 35 degrees, ulnar deviation 20 degrees, radial deviation 10 degrees, pronation 50 degrees, and supination 75 degrees. The assessment was traumatic tear of triangular fibrocartilage complex of left wrist; other closed intra-articular fracture of distal end of left radius; avulsion fracture of right wrist; and postoperative visit. X was to continue with therapy for range of motion, strengthening, and endurance and to allow full use.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "1. X. Official Disability Guidelines (ODG) recommends X, In this case, regarding the right wrist, review of claim supports that the claimant has X, The claimant also X. This request for X exceeds the guideline recommendations and there is no evidence of exceptional factors noted to support this request outside the guideline recommendations for the right wrist, Regarding the X, the claimant underwent left wrist surgery on X. Review of claim supports that the claimant was approved for X, The claimant X. Review of recent documentation indicates that there is regression with left wrist pronation with recent X. Additional same treatment without change in treatment plan would unlikely be beneficial. There is no documentation of assessment from the recently scheduled visit to the medical provider. Considering such, the medical necessity of this request is not established. 2. X. ODG recommends X. In this case, regarding the right wrist, review of claim supports that the claimant has X for the right wrist. The claimant also X. This request for X exceeds the guideline recommendations and there is no evidence of exceptional factors noted to support this request outside the guideline recommendations for the right wrist. Considering such, the medical necessity of this request is not established. 3.. ODG recommends X. In this case, regarding the right wrist, review of claim supports that the claimant has X for the right wrist. The claimant also X. This request for X exceeds the guideline recommendations and there is no evidence of exceptional factors noted to support this request outside the guideline recommendations for the right wrist. Considering such, the medical necessity of this request is not established. 4. X. ODG recommends X. In this case, regarding the right wrist, review of claim supports that the claimant has X for the right wrist. The claimant also X. This request for X exceeds the guideline recommendations and there is no evidence of exceptional factors noted to support this request outside the guideline recommendations for the right wrist. Considering such, the medical necessity of this request is not established. 5. X. ODG recommends X. In this case, regarding the right wrist, review of claim supports that the claimant has X for the right wrist. The claimant also X. This request for X exceeds the guideline recommendations and there is no evidence of exceptional factors noted to support this request outside the guideline recommendations for the right wrist. Considering such, the medical necessity of this request is not established."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "1. X. Official Disability Guidelines (ODG) recommends X. In this case, regarding the right wrist, the claimant has already X and notes no exceptional factors to support the request outside the guideline recommendations. After X, it is expected that the claimant would be independent in a home exercise program and at-home modality used to manage the current condition. Regarding the left wrist, the claimant is status post triangular fibrocartilage complex (TFCC) repair performed on X and has X to date. The evaluation of the left wrist shows a decrease in forearm pronation. There is a prior denial of the request due to the degradation in the forearm pronation as well. There is no change in the treatment plan mentioned. Additional treatment of the left wrist with no change in treatment plan would not bring about a different outcome for the claimant. Therefore, the request is not medically necessary. 2. X. Official Disability Guidelines (ODG) recommends X. In this case, regarding the right wrist, the claimant has already X and notes no exceptional factors to support the request outside the guideline recommendations. After X, it is expected that the claimant would be independent in a home exercise program and at-home modality used to manage the current condition. Regarding the left wrist, the claimant is status post triangular fibrocartilage complex (TFCC) repair performed on X and has X to date. The evaluation of the left wrist shows a decrease in forearm pronation. There is a prior denial of the request due to the degradation in the forearm pronation as well. There is no change in the treatment plan mentioned. Additional treatment of the left wrist with no change in treatment plan would not bring about a different outcome for the claimant. Therefore, the request X not medically necessary. 3. X. In this case, regarding the right wrist, the claimant has already X and notes no exceptional factors to support the request outside the guideline recommendations. After X it is expected that the claimant would be independent in a home exercise program and at-home modality used to manage the current condition. Regarding the left wrist, the claimant is status post triangular

fibrocartilage complex (TFCC) repair performed on X and has X to date. The evaluation of the left wrist shows a decrease in forearm pronation. There is a prior denial of the request due to the degradation in the forearm pronation as well. There is no change in the treatment plan mentioned. Additional treatment of the left wrist with no change in treatment plan would not bring about a different outcome for the claimant. Therefore, the request is not medically necessary. 4. X. In this case, regarding the right wrist, the claimant has already X and notes no exceptional factors to support the request outside the guideline recommendations. After X, it is expected that the claimant would be independent in a home exercise program and at-home modality used to manage the current condition. Regarding the left wrist, the claimant is status post triangular fibrocartilage complex (TFCC) repair performed on X and has X to date. The evaluation of the left wrist shows a decrease in forearm pronation. There is a prior denial of the request due to the degradation in the forearm pronation as well. There is no change in the treatment plan mentioned. Additional treatment of the left wrist with no change in treatment plan would not bring about a different outcome for the claimant. Therefore, the request is not medically necessary. 5. X. Official Disability Guidelines (ODG) recommends X. In this case, regarding the right wrist, the claimant has already X and notes no exceptional factors to support the request outside the guideline recommendations. After X, it is expected that the claimant would be independent in a home exercise program and at-home modality used to manage the current condition. Regarding the left wrist, the claimant is status post triangular fibrocartilage complex (TFCC) repair performed on X and has X to date. The evaluation of the left wrist shows a decrease in forearm pronation. There is a prior denial of the request due to the degradation in the forearm pronation as well. There is no change in the treatment plan mentioned. Additional treatment of the left wrist with no change in treatment plan would not bring about a different outcome for the claimant. Therefore, the request is not medically necessary.

Thoroughly reviewed provided records including provider notes and peer reviews.

The patient is recovering from wrist injury including TFCC tear that underwent repair on X. Prior to and after surgery, the patient has had a significant amount of surgery. Cited guidelines allow for X, of which, the patient has undergone X. Notably, the patient continues to have significant weakness and range of motion deficits around the wrist that is reportedly affecting their X. While the amount of therapy requested may be more than necessary to transition to a successful home exercise program, the patient can still benefit from X. Thus, some of the requested sessions are warranted despite going above the cited guideline recommendations. X is partially medically necessary and modified to X certified and the remaining X non-certified

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

Thoroughly reviewed provided records including provider notes and peer reviews.

The patient is recovering from wrist injury including TFCC tear that underwent repair on X. Prior to and after surgery, the patient has had a significant amount of surgery. Cited guidelines allow for X, of which, the patient has undergone X. Notably, the patient continues to have significant weakness and range of motion deficits around the wrist that is reportedly affecting their X. While the X may be more than necessary to transition to a successful home exercise

program, the patient can still benefit from X that could utilize techniques and modalities unavailable at home (including the X). Thus, some of the X are warranted despite going above the cited guideline recommendations. X is partially medically necessary and modified to X certified and the remaining X non-certified

Partially Overturned

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)**