True Decisions Inc.
An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #615
Mansfield, TX 76063
Phone: (512) 298-4786
Fax: (888) 507-6912
Email: @truedecisionsiro.com

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured at work on X, when X. X was X. The diagnosis was pain in right arm

and sprain of unspecified part of left wrist and hand.

On X, X presented to X, MD for follow-up of continued complaints of pain related to left wrist injury and right arm injury and to discuss the treatment for pain management. X continued to have to take X. X was doing X. X also continued to do X. X was scheduled to see orthopedic surgeon Dr. X again on X. X presented that day for X. X had injured X left wrist and right arm when X on X. X reported radiation of symptoms to the left and right hand. Pain in the right arm was constant and moderately severe. It was intermittent and moderate in the left wrist. Pan was described as shooting, throbbing, achy, and sharp. It was aggravated by reaching, raising or using the arms, and gripping, and was relieved by X. Associated symptoms included stiffness, pressure, soreness, and spasms. Affected activities of daily living included physical function, grooming, dressing, transfers, bathing, household chores, work, hobbies, sleep patterns, quality of life, and family and social life. X was unable to work. X score was X and X score was X. Neuromuscular examination revealed X. Right shoulder range of motion was X as well as X. Left wrist range of motion was improved with mild pain with flexion, extension, and rotation. The right shoulder revealed X Hawkins and Neer tests. The assessment was pain in right arm and sprain of unspecified part of left wrist and hand. Per the note, an MRI of the right shoulder done on X was reviewed and revealed X. An MRI of the left wrist dated X was reviewed and revealed X. The assessment was pain in right arm and sprain of unspecified part of left wrist and hand, initial encounter. X dose was decreased. X and X were X. A referral to X was provided.

An MRI of the right shoulder done on X was reviewed and revealed X. An MRI of the left wrist dated X was reviewed and revealed X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, and a peer review report dated X, the request for X was modified to certify X, by X, MD. Rationale: “ODG, Forearm, Wrist, and Hand Chapter Online Version (Updated X),X; Forearm, Wrist, and Hand states, "Wrist: Medical treatment: X. Radius or ulna (forearm): Medical treatment: X. "ODG Shoulder Chapter Online Version (Updated X, X, Shoulder states, "X: Medical treatment: X." Based on the provided documentation, the claimant has complaints of right arm and left wrist pain. Recent examination of

the right shoulder revealed X. There was tenderness to palpation of the right shoulder. Spasms noted. Examination of the left wrist revealed X. There was tenderness to palpation. In this case, case notes state the claimant was approved for X. Per the peer to peer discussion on X, X MD reports the claimant has an X. Claim review notes the claimant was approved for X. The treating provider was amenable to modifying the request to X. Therefore, the request for X is modified to certify X."

In a letter dated X, attorney X documented, "This is a preauthorization request for X. The medical provider, Dr. X, M.D., has requested this medical treatment because there is an ongoing condition(s) that requires treatment. The X is reasonable and is consistent with the Official Disability Guideline (ODG). The attached medical records support the efficacy of the treatment; and establish the clinical indication and necessity of this treatment. Therefore, the X should be determined medically necessary for claimant to reach MMI."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "I am recommending non-certifying the request for X: X for the following reasons: The claimant presented on evaluation with continued left wrist and right arm pain. X reported X helped improve their range of motion, mobility, and strength better than a X has. The neuromuscular examination revealed X. Prior report dated X, by X, MD, indicated the request for X was non-certified noting case notes state the claimant was approved for X. With pending X. ODG by MCG recommends up to X. In this case, the provided documentation indicates that the claimant has right shoulder and left wrist/hand pain for which X completed at least X on X. A request has been received for X, but the request exceeds the guideline recommendation, there is no indication that the X approved on X, were completed, and it is anticipated that the claimant would be able to transition to a X. Therefore, the request is recommended non-certified."

The ODG, Forearm, Wrist, and Hand Chapter Online Version (Updated X), X; Forearm, Wrist, and Hand states, "Wrist: Medical treatment: X. Radius or ulna (forearm): Medical treatment: X. "ODG Shoulder Chapter Online Version (Updated X), X: Medical treatment: X." The ODG Physical Therapy Guidelines state, "There are X: • An increase in the active regimen of care with a decrease in the passive regimen of care and a fading of treatment frequency. • The exclusive use of "passive care" (for example, X) is not recommended. • X should be initiated with the first X. • The use of

X. • Patients should be formally assessed after a "X" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the X). • When treatment duration and/or the number of visits exceeds the guideline recommendation, exceptional factors should be documented." Based on the submitted documentation, the requested X is not medically necessary. The record reflects that the claimant had X. The submitted records including the clinical examination does not support X. Furthermore, the requested 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:
The ODG, Forearm, Wrist, and Hand Chapter Online Version (Updated X), X; Forearm, Wrist, and Hand states, "Wrist: Medical treatment: X. Radius or ulna (forearm): Medical treatment: X. "ODG Shoulder Chapter Online Version (Updated X), X, Shoulder states, "X: Medical treatment: X." The ODG X Guidelines state, "There are X: • X. • The exclusive use of "passive care" (for example, X) is not recommended. • X should be initiated with the X. • The use of X will facilitate the X. • Patients should be formally assessed after a "X" to see if the patient is X. • When treatment duration and/or the number of visits exceeds the guideline recommendation, exceptional factors should be documented." Based on the submitted documentation, the requested X is not medically necessary. The record reflects that the claimant had previously completed X. The submitted records including the clinical examination does not support X. Furthermore, the requested X. No new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified

Upheld

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