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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Case Number: X Date of Notice: X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X worked as a X. X stated X wrist went into ulnar deviation, and X felt an immediate onset of pain. The diagnosis was pain in the left wrist, contusion of left wrist, and other specific joint derangements of left wrist.

On X, X was evaluated by X, MD, for follow-up. X had left wrist ultrasound on X that demonstrated “X."
MRI performed at X was read as X; however, when Dr. X reviewed the MRI, the possibility of a X was noted. X continued to complain of the instability of the X. X had X. X had tried X for X months without improvement. X had X, which provided X. This injury had prevented X from returning to work without restriction. Examination of the left wrist revealed X. X had X. X was tender over the X. X had a X. It was noted X had exhausted X at the time for greater than X months after X injury. X was offered X for management of the symptoms, and X elected to proceed with X.

An MRI of the left wrist dated X, demonstrated no significant abnormality.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X, was denied by X, MD, as not medically necessary or appropriate. Rationale: “Based on the review of the provided documentation, the claimant had complaints of the left wrist. Per ODG, Recommended as indicated below for X. According to the most recent note, the left wrist revealed tenderness of the X. The claimant does have X. Tender over the X. X press test. However, an MRI of

the left wrist taken on X revealed X. As there is no evidence of a tear on MRI, the requested X is not medically necessary at this time due to inconsistent findings."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "ODG by MCG Last review/update date: X, X: Surgery Related Topics: X. Click-through and see related topics field. ODG by MCG Last review/update date: X, X: X. ODG Criteria X. X. X. Peer Reviewed Literature cited: X: X DOI: X. Surgical treatment is indicated in refractory cases despite nonoperative treatment and may consist of repair of the X. An X is detailed. All of the listed records were reviewed. The patient is a X who sustained an injury on X. The patient was diagnosed with X - Contusion of left wrist, subsequent encounter. The requested X is not medically necessary. The submitted records and imaging reports X. Thus, the guidelines have not been met. Therefore, the request for X is not medically necessary and non-certified."

The claimant had described ongoing pain at the left wrist despite X. The claimant reported limited relief from a X. The current physical exam noted X. There was tenderness to palpation over the X. However, the X left wrist MRI report did not identify any specific pathology that would correlate with the claimant's reported symptoms or physical exam findings. The lack of MRI report findings for the left wrist would not support proceeding with the proposed X. As such, it is this reviewer's opinion that the services in question to include X is not medically necessary and the previous denials are upheld. 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 claimant described ongoing pain at the left wrist despite X. The claimant reported limited relief from a X. The current physical exam noted X. There was tenderness to palpation over the X. However, the X left wrist MRI report did not identify any specific pathology that would correlate with the claimant's reported

symptoms or physical exam findings. The lack of MRI report findings for the left wrist would not support proceeding with the proposed X. As such, it is this reviewer's opinion that the services in question to include X is not medically necessary and the previous denials are upheld. 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

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☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE