P-IRO Inc.
An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 779-3287
Fax: (888) 350-0169
Email: @p-iro.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

P-IRO Inc

Notice of Independent Review Decision

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 was on a X. The X and X sustained a X. The diagnosis was other closed fracture of distal end of right radius, initial encounter; and DeQuervain's tenosynovitis, right.

On X, X attended X. The primary diagnosis was right radius and ulnar open reduction internal fixation. The secondary diagnosis was stiffness, loss of range of motion, loss of functional use, scar condition, and effusion. X reported X wanted to be able to work on X grip strength more at home. It was assessed X was making good progress toward goals. Wrist flexion improved from X to X degrees during treatment session. X was progressing well. It was recommended that X continue to attend X. Skilled therapy would include: therapeutic exercise, therapeutic activities, manual therapy, soft tissue mobilization techniques, stretching / flexibility activities, joint mobilization techniques as needed, proprioception training, sensory integration and reeducation, neuromuscular re-education, self-care/home management, adaptive equipment education as needed, modalities as indicated, orthotics as indicated, orthotic training and education, and patient education. The comparative right upper extremity range of motion measurements on X as compared with initial evaluation of X were as follows: Wrist extension was X degrees as opposed to X degrees on X. Wrist flexion was X degrees as opposed to X degrees on X. Wrist ulnar deviation was X degrees as opposed to X degrees on X. Wrist radial deviation was X degrees as opposed to X degrees on X. Forearm supination was X degrees as opposed to X degrees on X. Forearm pronation was X degrees as opposed to X degrees on X. Circumferential measurements at wrist crease were X cm on X as opposed to X cm on X. Average grip strength on the right on X was X pounds, as opposed to X pounds with pain on X. Lateral pinch strength on the right on X was X pounds, as

opposed to X pounds on X; X-point pinch strength on the right on X was X pounds, as opposed to X pounds on X; X-point pinch strength on the right on X was X pounds, as opposed to X pounds on X. On X, the DASH was X, the numbness in the thumb was improving, and incision sites were covered and not assessed. On X, the DASH was X. X visited X, MD on X, nearly X months and status post right distal radius and ulna fracture ORIF on X. X reported some improvement in pain after X. X reported some restriction in range of motion, specifically with wrist extension and flexion and some weakness with strength. On right wrist examination, the incisions were well healed. Extension was to X degrees, flexion to X degrees, supination X degrees, and pronation to X degrees. There was tenderness noted at the X. Dr. X assessed that X still lacked some strength and range of motion and so, wanted to continue with X. They would attempt to get this approved again to help X progress. X still had X. The assessment was other closed fracture of distal end of right radius, initial encounter; and DeQuervain's tenosynovitis, right.

Treatment to date included X.

Per a utilization review / adverse determination letter dated X, and a peer review dated X, the request for X was denied by X, DO. Rationale: "According to Official Disability Guidelines, X. The visit recommendations outlined below serve as benchmarks for the expected number and duration of X. These benchmarks do not X. The inclusion of a diagnosis in the ODG Criteria does not imply that all patients with that diagnosis require X. The decision to X. Additional visits may be clinically appropriate in specific circumstances, particularly when prior treatment has resulted in measurable and meaningful functional improvement. Such circumstances may include X. For general X that apply across all diagnoses, including considerations that may not be explicitly addressed within each guideline, please refer to the X. Fracture: Radius or ulna (forearm): Postoperative treatment: X," In this case, the claimant is diagnosed with a closed fracture end of radius. The claimant is X months status post right radius fracture. The claimant is doing well. No physical examination was recorded. There is evidence that the

claimant has attended X. Additional X exceeds the allowable maximum number of visits. Therefore, the request is not certified."

A letter of appeal dated X, by X, OTR, was documented to appeal the denial of X authorization for X. X was a X who sustained a right radius and ulna fracture, and was status post open reduction internal fixation (ORIF). Subsequently, X developed symptoms of DeQuervain's tenosynovitis. This had resulted in ongoing challenges affecting X daily activities and quality of life. To effectively manage X injury, X recommended X. This treatment was essential for the following reasons: 1. X. 2. X. 3. X. X currently had X pounds on grip strength on X dominant right side versus 66 pounds on X left. X had a disability index score of X, indicating X normal functional use of X dominant right upper extremity.

Per a reconsideration review / adverse determination letter dated X, and a peer review dated X, the appeal request for X was denied by X, MD. Rationale: "The request is not medically necessary. This claimant was diagnosed with a closed fracture of distal end of radius and tenosynovitis of right radial styloid. The claimant is following up after a radius fracture and ORIF on X. The claimant reports they are slowly improving, but with continued limited flexion. A physical examination was not performed. The treatment plan is for X. A prior review by Dr. X, DO dated X denied the request on the basis that no physical examination was recorded and the claimant has attended X. Additional X exceeds the allowable maximum number of visits. Appeal letter by X, OTR dated X noted the claimant is post ORIF and developed deQuervain's tenosynovitis with ongoing challenges affecting quality of life. The treatment is essential for pain management, improving range of motion, and functional improvement. Per ODG, "Radius or ulna (forearm): Postoperative treatment: X." In this case, there is no recent office note with X. Additional X is excessive in nature. There is no significant evidence provided for review, that would indicate the claimant can not address any current and/or remaining deficits with X. Medical necessity has not been established. Therefore, the request for the APPEAL X is not medically necessary."

P-IRO Inc

Notice of Independent Review Decision

Case Number: X Date of Notice: X

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

In this case, the records document the claimant was diagnosed with a closed fracture of distal end of radius and tenosynovitis of right radial styloid. The claimant is following up after a radius fracture and ORIF on X. The claimant reported they are slowly improving, but with continued limited flexion. A physical examination was not performed. The treatment plan is for X. Per ODG, "Radius or ulna (forearm): Postoperative treatment: X." In this case, there is no recent office note with X. Additional X is excessive in nature. There is no significant evidence provided for review, that would indicate the claimant cannot address any current and/or remaining deficits with X. Medical necessity has not been established. Therefore, the request X is not medically necessary and upheld.

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

P-IRO Inc

Notice of Independent Review Decision

Case Number: X Date of Notice: X

☐ 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