Applied Resolutions LLC
An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #790
Mansfield, TX 76063
Phone: (817) 405-3524
Fax: (888) 567-5355
Email: @appliedresolutionstx.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. X stated that on X, around X. The diagnosis was other synovitis and tenosynovitis, left forearm; closed displaced fracture of styloid process of left ulna with nonunion, subsequent encounter; other specified sprain of left wrist, subsequent encounter.

On X, X visited X, MD, for imaging follow-up. X followed up regarding X left wrist. X had obtained an MRI that showed X. X was still pretty painful with it. X also had a X. Left upper extremity range of motion revealed X. X was tender on the X. The X. The distal radioulnar joint did not subluxate in any position of rotation. The MRI was reviewed. The X. The sheath appeared intact, other than being full and stretched. The X had discontinuity at the central aspect and a little bit of ulnarward to that. The assessment was X. An X was performed to the left wrist through the X. Dr. X discussed surgery to X. X would be off work a few days from that and then back to light duty, and then possibly at normal duty in a month.

An MRI of the left wrist dated X, demonstrated X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “The patient was X. The patient extended their arm and lifted to X. Physical examination findings of the Left wrist revealed a X. The patient is tender on X. The X is X. The X. Prior treatment and response: X; X on X. On X - X, X, MD, evaluated the patient for a left wrist ulnar styloid fracture with chronic nonunion, sprain, and extensor carpi ulnaris tenosynovltis. The patient reported ongoing pain, particularly when rotating while holding weighted objects. Physical examinations revealed X. Treatment included X. The X provided pain relief and improved range of motion. The requested X is not medically necessary. The submitted medical records including the imaging report does not demonstrate the presence of a X. In addition, no documentation has been provided to demonstrate that the patient has X. Thus, medical necessity cannot

be established. Therefore, the requested X is not medically necessary."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "I am recommending upholding the request for APPEAL: X for the following reasons: ODG by MCG recommend X. ODG by MCG do not address the request for X. The function of the X is to act as a X. The X is at risk for either acute or chronic degenerative injury. ODG by MCG recommend X. Given the paucity of high-level research regarding treatment, there is still debate about whether anatomical or nonanatomical techniques lead to better outcomes. No single technique has been proven to be individually superior. Further research on X. ODG by MCG do not address the request for X. Per alternative guideline, the treatment of the X. Per alternative guideline, the primary goal of X is to X. ODG by MCG state that assistant surgeon is recommended as an option for more complex surgical procedures, following appropriate coding and billing procedures. Based on the review of the documentation provided, the claimant complained of left wrist pain. X has an X. X is still pretty painful with it. X also has a X. The examination findings revealed that the claimant is tender on the X. The provider discussed X to X. The claimant would be off work for a few days from that and then back on light duty and then possibly at normal duty in a month. X is in pain today and would like an X and has had X. A prior utilization review determination by X, MD, on X, non-certified the request for X. The requested X is not medically necessary. The submitted medical records, including the imaging report, do not demonstrate the presence of a X. In addition, no documentation has been provided to demonstrate that the claimant has attempted an X. According to the most recent note, the claimant is tender on the X. However, an MRI of the left wrist taken on X revealed X. Non-united fracture of the ulnar styloid process. There is no evidence of X. Moreover, there is no documentation detailing the X. The provider has not provided any new clinical findings or compelling information to support overturning the prior noncertification. As such, the requested APPEAL: X is not medically necessary. Therefore, the request is recommended upheld."

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

Based on the review of the provided documentation, the claimant had complaints of the left wrist. An MRI of the left wrist dated X, demonstrated X.

According to the most recent note of X, the left upper extremity range of motion revealed the X. The X was full of tenosynovitis. The distal radioulnar joint did not subluxate in any position of rotation. Treatment to date included X. Due to the claimant's persistent limitations despite conservative care, the requested X is medically necessary.

Overturned

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