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Notice of Independent Review Decision

Amendment X

IRO REVIEWER REPORT

Date: X; Amendment 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 on X. Per records, X was injured when X was X. The diagnosis was brachial plexopathy (X).On X, X was seen by X. MD for a follow-up visit. X presented with a complaint of right arm pain. X underwent a X on X. The pain before X was X and after X was X. X stated that the X. The pain was located at the right hand. The pain was described as burning and tingling. X denied numbness. X wore a wrist brace for support. The pain was worse in the afternoon time. The pain was better with lying down and X. The pain worsened with standing and walking for long periods of time. X rated pain as ongoing X, average X, at least X and maximum pain was X. The X had X. X had X. At the time, X was taking X. X reported X. X reported treatment / medication relief was X. X reported adequate relief to improve function with ongoing X. On examination, weight was 176 pounds and body mass index was 29.29 kg/m2. Examination of upper extremities revealed there was wasting of all group of muscles extending from shoulder girdle to hand. Motor strength was X. There was X. Sensory examination to touch and pinprick indicated numbness in the right upper extremity. The tendon reflexes were absent. X had a significant loss of muscle mass. The right upper extremity was about one third the size of the left upper extremity. X was wearing a splint and the wrist to avoid contractures. There were significant contractures in the X. Sensory and motor examination was unremarkable in the left upper extremity. X was wearing the splint in the right wrist. The right arm revealed significant X. Cervical spine

examination showed X. X was painful. There was severe X. Treatment plan included X. X was restarted and X was advised to continue X. X was discussed. On X, X was seen by Dr. X for a follow-up visit for right arm pain. X rated pain as ongoing X, average X, at least X and maximum pain was X. X reported treatment / medication relief was X. Examination was unchanged. X had continued pain in the right hand. X had a new pain in X hand recently on the top of X hand, at the time. X was seen by hand surgeon, Dr. X after X year of trying to see X due to insurance denying the request. The physician had recommended X. X had X. X reported improvements in the activities of daily living (ADLs) with the pain medicine. For better pain control, X would continue with ongoing medication. Dr. X appealed for the X. X was started and was advised to continue X. Treatment to date included use of X. Per a utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: “The request is for X. Per the ODG guidelines, X is not recommended as there are still gaps in knowledge requiring further research and X. In this case, although the individual had some relief with the previous X, per the available records, the individual is having adequate relief with the current medication regimen as well. As such, the need for X remains questionable at this time. During discussion, it was stated that the proposed X. It was also stated that the individual has X. However, there is non-recommendation of the use of this treatment per the guidelines due to very little research and associated concerns for X. As such. given that there is insufficient literature recommending this treatment modality for treatment for X, the medical necessity of the requested treatment is not established. Therefore, the request for X is not medically necessary or appropriate and is denied. “Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Per ODG, "Not recommended, including several terms and device variations including X." ODG also notes regarding this treatment that there are knowledge

gaps which require further research. In this case, the claimant presented with ongoing chronic right arm pain. Evidence-based guidelines do not support this modality. There are no exceptional factors noted in this clinical scenario. The recommendation is for non-certification of the request for X. Because an adverse determination for X has been rendered, an adverse determination for X is also rendered. “Thoroughly reviewed provided records including peer reviews. Patient with continued X. X underwent X which was unsuccessful. Now being consider for X but rejected by peer reviews based on ODG criteria. However, X may still be considered in this case given patient has tried X. X is medically necessary and certified.

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

Thoroughly reviewed provided records including peer reviews. Patient with X. X underwent X which was unsuccessful. Now being considered for X but rejected by peer reviews based on ODG criteria. However, X may still be considered in this case given patient has X. X is medically necessary and certified.

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

☐ 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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL