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Notice of Independent

Review Decision

IRO REVIEWER REPORT

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:

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether **medical necessity exists** for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X whose date of injury is X. The patient was involved in a X. The patient underwent cervical X in X. Psychological evaluation dated X indicates that the patient X to repair X right thumb, most recently in X. X had a X in X with
X. There is no evidence of psychopathology that would make X. The patient was noted to be psychologically stable enough to tolerate spinal X. X dated X shows evidence of a severe right X at the X. Findings are compatible with electrophysiological evidence of a right X radiculopathy. The patient underwent X. Physical therapy plan of care/initial evaluation dated X indicates that diagnosis is other cervical X. Cervical X is X. X is X upper X. Psychosocial assessment dated X indicates BDI is X and BAI is X. X was recommended for X. Physical therapy progress report dated X indicates that X reports X. Office visit note dated X indicates chief complaint is X and right thumb X. Medications include X. X :X. On physical examination there is cervical X. There are lumbar X. There is pain with cervical X. There is X. X is X on the right. X is X right X and

finger , left X. There is X and X following X. Diagnosis: unspecified X of right thumb; X of ligaments of cervical X ; X right X. There is noted to be X changes noted to the right X. The right X pain has not improved after X. This report states, "X." There was reportedly no relief with X. Office visit note dated X indicates that pain is X. Cervical X shows pain with right X. There is X. X is X on the right.

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

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. The initial request was non-certified noting that the request was for a X. The provided notes do not indicate that there has been any previous X performed nor has there been any previous X. Furthermore, the physical examination performed on X does not reflect a diagnosis of chronic regional pain syndrome. The denial was upheld on appeal noting that records indicate X on X with X. Records do not indicate X. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient underwent a X. Addendum dated X indicates that the patient has had cervical X in X and has X. The X is now recommended for X. However, current evidence based guidelines note that X are not recommended for treatment of the cervical X as evidence shows inconclusive benefit, lack of benefit, or potential harm. The psychological clearance provided is over X. The updated psychological assessment does not address the patient's suitability for the requested procedure. Therefore, medical necessity for the X is not established in accordance with current evidence based guidelines

and would not be medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE

IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES