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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 Overtuned Agree in part/Disagree in part

☒ 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]: X with a date of injury of X. The mechanism of the injury was not available in provided medical records. The diagnoses were radiculopathy of cervical region (M54.12), cervicalgia and fusion of spine of cervical region.On X , X was seen by X , APRN for follow-up visit for X . X stated that X reported that X. X was doing X. X stated that then X. X was in the X. X was still in the process of X. X had X. At the time, X was taking the X. X had been going back to X. X would be going to see Dr. X on the X. X had been getting a X. The quality of pain included X. The severity of pain revealed X. X had X. X activities of daily living had X. The aggravating factors included X. The relieving factors included X. X had diagnostic thoracic / cervical facet block at 2 levels C5-C6 and C6-C7 bilateral on X and X pain level prior to the procedure was X. On examination, X blood pressure was 120/89 mmHg, weight was 170 pounds, and BMI was 26.62 kg/m2. X appeared to be in X. The X examination revealed X. The X. There was left greater than right X. The cervical muscles revealed X. There was X. The X was decreased as X. The sensory examination revealed X. The X was seen in X. The myofascial examination revealed X. The X test, X , X test, X test, X test, X test, X test were X. The X revealed X. X was recommended for X. An X of the cervical X dated X showed X. This resulted in X.A X of cervical X dated X showed X. There were degenerative changes at X. Per a utilization review adverse determination letter dated X, the request for cervical X was denied by X, MD. Rationale: “The history and documentation do not objectively support the request for left X.” “In this cases there is no clear evidence of X on the left side at two levels with findings on physical examination that are consistent with the MRI findings. The MRI does not demonstrate X. Also, there is no evidence of X. The medical necessity of this request has not clearly been demonstrated. A clarification/modification was not obtained.” An appeal letter dated X included in the records for the denial X. Per a reconsideration / utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “No additional new data submitted for appeal review. X still remains X. Also, there is X.” Thoroughly reviewed provided records including provider notes, imaging results, and peer reviews. Patient with complex multifactorial pain issues

extending over a decade. APRN seeing patient now requesting X. Agree with peer reviews that it is unclear what treatment including X. It is also unclear based on subjective complaints, objective findings, imaging results if there is any pathology on imaging that correlates with a dermatomal distribution that could explain a potential X. X not indicated. 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:

Patient with complex multifactorial pain issues extending over a decade. APRN seeing patient now requesting X. Agree with peer reviews that it is unclear what treatment including X. It is also unclear based on subjective complaints, objective findings, imaging results if there is any pathology on imaging that correlates with a dermatomal distribution that could explain a potential X. X not indicated. 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:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**