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Notice of Independent Review Decision

Reviewer's Report

DATE OF REVIEW: 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:

☐ Upheld (Agree)

☒ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

I have determined that X is medically necessary for treatment of this member's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. X

PATIENT CLINICAL HISTORY [SUMMARY]:

This member is a X for whom coverage was requested for X. The Carrier denied coverage for these services on the basis that this service is not medically necessary for treatment of the member's condition.

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

The Maximus physician consultant explained that a progress note dated X indicated that the member presented for X. It noted that the member still reported that X pain remains at a level of X out of X. It indicated that the member continued to have pain in the X. It noted that magnetic resonance imaging (MRI) was completed of the left shoulder which revealed a X. There are examination findings of decreased strength and decreased sensation in the X distribution.

The Maximus physician consultant indicated that the Official Disability Guidelines and Treatment Guidelines (ODG) note that for X that criteria includes radiculopathy (irritation or injury to a nerve root that typically causes pain and/or numbness or weakness in the part of the body supplied with the nerves from that root) must be well documented, along with objective neurologic findings on physical examination. Acute radiculopathy must be corroborated by advanced imaging studies (for example [e.g.,] computed tomography scan, magnetic resonance imaging) and, when appropriate, electrodiagnostic testing, unless documented pain, reflex loss, and myotomal weakness abnormalities support a dermatomal radiculopathy diagnosis. A request for a procedure in a patient with chronic radiculopathy requires additional documentation of recent symptom worsening associated with deterioration of neurologic state. It also requires that the member be unresponsive to conservative treatment (e.g., exercise, physical therapy (PT), nonsteroidal anti-inflammatory drugs, muscle relaxants, neuropathic drugs).

The Maximus physician consultant noted that the notes report physical findings of radiculopathy based on motor and sensory changes reported in cervical X dermatome. The notes reflect X. The member has used X. While the X is performed at X to X interspace. The medication travels in the X. As such, X is supported congruent with ODG guidelines.
Therefore, I have determined that coverage for X is medically necessary for treatment of this member's condition.

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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES: NECK AND UPPER BACK, EPIDURAL STEROID INJECTION (ESI) FOR NECK AND UPPER BACK CONDITIONS**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TMF SCREENING CRITERIA MANUAL**

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

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