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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

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X worked as a X. X was X. X stated X was X. The diagnosis included cervical radiculitis, neck sprain, strain of tendon of neck, thoracic back sprain and strain of back muscle. On X, X was seen by X, DO for X ongoing complaints. X continued to do well following X. X were X that day and X wanted to conclude this care X. Continued exercise, X was advised. X did not X. As a result, X wanted to go ahead with X. X had X with Dr.X. X effect had improved accordingly. X was satisfactory. X were X. As a result, X was recommended in the near future. On X, X was seen by X, DO to discuss care after completing a X. Neck pain was rated X with pain in left shoulder after X the previous day. Examination showed cervical range of motion included right rotation to X degrees, left rotation to X degrees, extension to X degrees and flexion to X degrees with pain. X was noted. Deep tendon reflexes in left biceps, left brachioradialis, right and left triceps was X and in right biceps and right brachioradialis was X. X was prescribed and follow up with Dr. X was recommended. An MRI of the cervical spine dated X revealed degenerative changes in the cervical spine.X: X was noted.X: X with slight X. X was noted. Treatment to date included X on X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “The Official Disability Guidelines discusses X. Such treatment is generally recommended on a limited basis generally for X. Specific objective benefit of this treatment is not available. Therefore, the request is not medically necessary. “Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Per date of service X, the injured worker is X. On X, neck pain X and left shoulder pain. Physical examination reveals j X. However, there is no specific documentation of X improvement, reduced medication use, and functional improvement. Therefore, the request is

not medically necessary. “X is not medically necessary. The medical documentation does not demonstrate functional improvement following X. There is no documentation of percentage of improvement following these X. No new information has been provided which would overturn the previous denials. 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:

A X is not medically necessary. The medical documentation does not demonstrate functional improvement following prior X. There is no documentation of percentage of improvement following these X. No new information has been provided which would overturn the previous denials. 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**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**