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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. X.

PATIENT CLINICAL HISTORY [SUMMARY]:

This member is a X for whom authorization and coverage was requested for X. The Carrier denied coverage for these services on the basis that these services are 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 X indicated that the X note reported ongoing neck pain with radicular pain for more than X months that has not responded to X. Physical examination notes X. There was X. The X magnetic resonance imaging (MRI) of the cervical spine reported X. It was reported that the member has X.

The X noted that the Official Disability Guidelines (ODG) notes for X. Acute radiculopathy must be corroborated by advanced imaging studies (for example [eg,] 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 along with being unresponsive to conservative treatment (eg, exercise, physical therapy, nonsteroidal anti-inflammatory drugs, muscle relaxants, neuropathic drugs).

The X consultant indicated that the documentation reports physical X. The notes reflect failure of X. The member has used X.

The X noted that while the X is performed at the X. The documentation reports that the member has X. As such, X is supported congruent with ODG guidelines.

Therefore, X have determined that authorization and coverage for X is medically necessary for treatment of the 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:**

☐ **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)**