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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

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 case concerns a X who has requested authorization and coverage for X. The Carrier denied this request on the basis that these services are not medically necessary for treatment of the member's condition.

On X, the member's treating physician wrote a letter in support of this request. It indicated that this member has been diagnosed with chronic regional pain syndrome (CRPS) to the right upper extremity and X has X. It noted that the member is currently under the care of a doctor who has recommended X. It indicated that X were reviewed and the doctor indicated X. It noted that instead of resolving or reducing the member's pain to the right upper extremity, this X. It indicated that this clinically is what you would expect from X. It noted that the request for X. It indicated that it should be clear that the X. It noted that with addressing those issues, there is a clear likelihood that the

member will undergo some improvement in X current pain level which may allow improvement also in X function which is the goal of X.

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

The Maximus physician consultant explained that a note on X indicated that the member was diagnosed with CRPS to the right upper extremity and X has X. It noted that the member is currently under the care of a doctor who has X. It indicated that X. It noted that instead of resolving or reducing the member’s pain to the right upper extremity, this X. It indicated that this clinically is what you would expect from X. It noted that the request for X.

The Official Disability Guidelines (ODG) on chronic pain and CRPS, supports the use of X. The American Society of Regional Anesthesia (ASRA) X Interventional Pain guidelines and International Spine Intervention Society (ISIS) X Interventional Pain guidelines support the X. The available medical records do indicate diagnosis of such condition. The records support that a X. Repeat trial is supported congruent with ODG and peer reviewed guidelines to attempt X.

Therefore, the requested coverage for requested 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**

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