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Notice of Independent Review Decision
Amendment X;Amendment X

IRO REVIEWER REPORT

Date: X; Amendment 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: •

PATIENT CLINICAL HISTORY [SUMMARY]: X is a X who was injured on X.X suffered a X. X noticed a sudden pull in X shoulder, neck, arm and hand. The diagnosis was chronic neck pain syndrome with left cervical radiculopathy, cervicogenic headache with cervical facet syndrome and chronic left shoulder pain. On X, X, DO evaluated X for a follow-up. X presented in a wheelchair. X stated X had been off and on medications. It was explained that this was not judicious use of medication management, and it was quite dangerous to withdraw suddenly from X. X stated that X tried that "make it last.". X X would be refilled. X was being treated for neck and low back areas. At the time of visit, X had moderate X. Over X months prior, X got excellent relief of pain in that area with a X. As a result, X wanted to reinstitute care in this area including X X utilizing a X was able to X. X did have moderate X. An MRI of cervical spine dated X revealed straightening of X. There was shallow X. These were new when compared with X. These did not result in X. There was X. There was X. Treatment to date included medications (X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Per a review of the medical report and cited guidelines, the request is not warranted. The cited guideline supports X. A X is necessary when there is documented sustained improvement equal to or greater than X for at least X weeks and there is pain or deterioration afterward. Use of general anesthesia, moderate or deep sedation, or monitored anesthesia care are not recommended. A prior request for X was certified in review X. on X considering the lack of continuous benefits from X. The claimant had X. They now had pain with left rotation, disruption, moderate midcervical

interspinous tenderness, and positive Spurling's test. Their MRI demonstrated shallow X. The request is not reasonable as there were X. Also, the approach to be used is unknown. Given the above information, the prospective request for X is non-certified. “Per a utilization review adverse determination letter dated X, by X, MD, the request for X is denied. Rationale: “Per review of the medical report and cited guideline, the request is not warranted. The cited guideline X. A X is necessary when there is documented sustained improvement for equal or greater than X for at least X weeks and there is pain or deterioration afterwards. The use of X is not supported. A prior request for X was non-certified per review X on X as there were X. Also, the approach to be used is unknown. The claimant had chronic neck pain that radiated to their left arm and hand with numbness in the X. They also had limited X. They had X. Their MRI demonstrated X. The request is not reasonable as there were X. Also, there was no specific documentation that X. Given the above information, the prospective request for X is non-certified.” On X, an appeal for X was provided. Per a reconsideration / utilization review adverse determination letter dated X, by X, MD, the request for X is denied. Rationale: “Per a review of the medical report and cited guidelines, the request is not warranted. The cited guideline supports X. A X is necessary when there is documented sustained improvement equal to or greater than X for at least X weeks and there is pain or deterioration afterward. The use of moderate or X is not supported. A prior request for X was non-certified per X on X as there were no current corroborative objective findings of cervical radiculopathy to warrant X. Also, the approach to be used is unknown. The claimant had chronic neck pain that radiated to their left arm and hand with numbness in the X. They also had X. They had X. Their MRI demonstrated XX. The request is not reasonable as there were X. Also, there was no specific documentation that their X is non-certified. “Thoroughly reviewed provided records including provider notes and peer reviews. Patient with continued pain issues described as neck pain radiating down left upper

extremity in to hand. X purportedly found relief from X. The provider is considering a X. While the cited ODG criteria does recommend documentation of X pain relief for at least X weeks, given provider's documentation that patient had significant pain relief and both provider in patient X. X is medically necessary and certified.

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

Thoroughly reviewed provided records including provider notes and peer reviews. Patient with continued pain issues described as neck pain radiating down left upper extremity in to hand. X purportedly found relief from X. The provider is X. While the cited ODG criteria does recommend documentation of X pain relief for at least X weeks, given provider's documentation that patient had significant pain relief and both provider in patient X, request is warranted. Prospective request for X is medically necessary and certified.
Overturned

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)**