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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 Overturned 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. Per records, the claimant had work-related injury; however, the biomechanics of the injury is not available in the records. The diagnosis was complex regional pain syndrome I of the right upper limb; chronic pain syndrome; pain in the right arm; other long-term (current) drug therapy; encounter for the issue of X; monoplegia of the upper limb affecting unspecified side; pain in the left arm; other muscle spasm; opioid dependence with unspecified opioid-induced disorder; and complex regional pain syndrome I of the unspecified upper limb.

***There were no office visits and/or imaging studies available in the provided records.

Treatment to date per records included X.

Per a utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: “Per ODG, "X is not recommended for most chronic pain conditions. Also, not recommended for the following: X. Studies have found no

statistical support for the use of X for those conditions: In this case, claimant has a chronic injury. The most recent medicals indicate the claimant has X pain with medications, X without medications, and the claimant does not feel down, depressed, or hopeless over the past two weeks. On exam, forward head position with anterior skull translation and internal rotated protected shoulders, positive bilaterally, tenderness along facet joints, trigger points noted with reproduction of referred pain pattern, palpable myospasm noted, restricted ROM in lateral bending and rotation. The plan indicates for X for arm pain, as X was repeated and the claimant is feeling much better, pain is reduced, and function is improved. The current request is not medically necessary for this claimant, who has arm pain, and ODG states that X is not recommended for most chronic pain conditions. Therefore, the request for X is not medically necessary and non-certified."

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. This was an appeal to review X. Rationale: "In this case, X are proposed for treatment of right upper extremity pain that has been attributed to complex regional pain syndrome. Evidence is lacking to recommend X. Although "spasticity" was documented as the indication for X. As also noted on prior reviews, research concerning X. Complex regional pain syndrome is not an upper motor neuron syndrome and motor signs of complex regional pain syndrome are not equivalent to spasticity caused by an upper motor neuron injury. Therefore, the request for Appeal Request: X is not medically

necessary

Thoroughly reviewed provided records including peer reviews. No clinic notes noted. The patient is being treated for right upper extremity pain issues. May have some component of spasticity given apparent monoplegia but missing significant exam to document spasticity of entire right upper extremity to warrant X. Also, X is not a treatment option for complex regional pain syndrome. 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:

Thoroughly reviewed provided records including peer reviews. No clinic notes noted. The patient is being treated for right upper extremity pain issues. May have some component of spasticity given apparent monoplegia but missing significant exam to document spasticity of entire right upper extremity to warrant X. Also, X is not a treatment option for complex regional pain syndrome. 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:

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

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

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

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☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE