US Decisions Inc.
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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 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:

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☒ 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: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured at work on X, when X was X. X suffered severe injuries of X. The diagnosis was chronic neck pain syndrome with right cervical radiculopathy associated with cervical disc disruption and cervical radiculopathy at X and X following a work injury. On X, X was evaluated by X, DO, who noted that X was doing extremely well regarding X axial back, buttock and leg pain. Utilizing X, X was getting excellent coverage. X was more functional and more active and X was working in a volunteer capacity. X was off X. X main complaint continued to be X. As a result, X wanted to proceed with X. Dr. X was recommending that X. At the time, X had decreased grip strength on the left, decreased pinprick in the X. Dr. X responded to the peer review denial for this reasonably necessary care under the Texas Labor Code. X was consistently showing good compliance with treatment. X back was much better. X was walking. X was exercising. They did reanalyze X across three parameters that day and would schedule X for X. X did have a positive Spurling testing with impulse pain into the left shoulder that day. No updated imaging was available for review. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “Regarding the X, the Official Disability Guidelines (ODG) state that X is recommended for X. The X was performed

at X. The procedure is performed under fluoroscopic or CT guidance. It is not recommended to use general anesthesia, moderate or deep sedation, or monitored anesthesia care. There should be a failure to respond to conservative treatment. Repeat X in a patient with good response to X, as indicated by documentation of sustained improvement of pain or function of X. Based on the submitted documentation, the request is not supported. The cited guideline states that X in a patient with good response to X, as indicated by documentation of sustained improvement of pain or function of X. The medical submitted was dated X. Since there was nonprovisional of recent subjective complaints and objective clinical findings, work status, recent imaging results, and other treatments attempted that would demonstrate the medical necessity of the requested treatment, the request is not warranted at this time. Moreover, the use of X is not recommended. Therefore, the prospective request for X is non-certified. “Per an appeal review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “The request for a X was recommended non-certified by X, M.D. in X on X as there was non-provision of recent subjective and objective clinical findings needed to establish medical necessity. Also, the use of X was not indicated during the procedure. Based on the submitted document, the claimant sustained an injury X. The current work status was undisclosed. They were diagnosed with cervical radiculopathy. Prior treatments were X. They underwent an X. They were X on X per X. A CT scan of the cervical spine dated X showed X. There was X. Per the progress report by

X, D.O., PA, dated X, the claimant continued to have neck pain that radiated to the left arm and hand. A physical examination of the cervical spine showed X. A positive Spurling test was noted. Per X, the use of X was intended to manage their anxiety and fear of needles. Regarding outpatient X, the Official Disability Guidelines (ODG) recommend X. There should be significant pain and functional improvement of X or greater for at least X. There should be recurring pain and disability since X. The use of X is recommended. The mode of X. There should be no bleeding or clotting disorder or local or systemic infection. There should be less than X. The use of general anesthesia, moderate or deep sedation, or monitored anesthesia care are not recommended. Based on the information provided, the request is not warranted. The cited guideline requires them to have persistent signs and symptoms of cervical radiculopathy with supportive imaging showing spinal compression correlating with their symptoms following exhaustion of conservative measures and satisfaction of other guideline requirements. There should be functional improvement from their X. In this case, there was no documentation of significant pain reduction or X. Therefore, the appeal request for X is non-certified. “Thoroughly reviewed provided records including provider notes and peer reviews. Patient with acute on chronic cervical radiculopathy issues treated with X. Based on documentation provided, the patient appears to have both subjective pain relief as well as improvement of function at some point but appears to be greater than the minimal X. Dr. X implies that these improvements can

be attributed to X. Thus, X is being requested. The provider also documented at some point that the patient had significant anxiety regarding needles thus is requesting minimal sedation. Given the documentation supplied, the request is warranted. 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 acute on chronic cervical radiculopathy issues treated with X. Based on documentation provided, the patient appears to have both subjective pain relief as well as improvement of function at some point but appears to be greater than the minimal X. Dr. X implies that these improvements can be attributed to X. Thus, X is being requested. The provider also documented at some point that the patient had significant anxiety regarding needles thus is requesting X. Given the documentation supplied, the request is warranted. X is medically necessary and certified
Certified

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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)**