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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. X was on a X. X fell forwards X. X head hit a valve. Luckily, X had a hard hat on. It injured X neck and both shoulders. The diagnoses were paresthesia of skin, neck pain, cervical spondylosis, and bilateral carpal tunnel syndrome.

On X, X was seen by X, APRN / X, MD for neck pain and follow-up of X diagnostics. X was X, which helped. X had continued to complain of posterior neck pain. X had neck pain on a daily basis. It was constant. X rated it X. It increased with neck movement. X had X, but it did not help. X also complained of bilateral hand pain. X had been dropping things. X had bilateral hand numbness. On examination, the neck was nontender to palpation. Range of motion of the cervical spine revealed flexion X degrees, extension X degrees, and rotation X degrees to the left and right. Motor examination revealed X strength in all upper extremity muscle groups. Sensory examination was X. Reflexes were X and symmetric in the upper extremities and X and symmetric in the knees. Tinel's was X. An X was ordered.

An MRI of the cervical spine dated X showed X. Cervical spine x-rays dated X revealed X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Per ODG, it may be recommended as a X. In this case, the individual has neck and hand pain. However, the individual recently underwent an X. There is no formal documentation of any red flags to support an X. Further, there are X. Given these facts, the request for X is non-certified."

Per a letter dated X, Dr. X documented that X continued to complain of neck pain on a daily basis. X had X for the neck previous, but it did not help. X also

complained of bilateral hand pain, as well as bilateral hand numbness and weakness. X had been dropping things. An X was ordered to see if the hand numbness was coming from the stenosis noted on X or possibly from a X. Unfortunately, the X was denied. Dr. X would like to appeal this denial as an X was important in coming up with an accurate diagnosis for the patient so the proper treatment can be rendered.

Per a reconsideration review adverse determination letter dated X, the request for X was non-certified by X, MD. Rationale: "Guidelines conditionally recommend X when indicated. Per this appeal review, the individual complains of neck pain and bilateral hand numbness with objective findings of decreased ROM of the cervical spine and positive Tinel's over the bilateral wrists. This request was non-certified on a UR dated X citing a X. Per the appeal letter dated X, it is noted that the individual attended X in the past and noted that an X is important in coming up with an accurate diagnosis so the proper treatment can be rendered. However, there is no updated information to address the previous reasons for non-certification. There is no indication of the extent of prior X such as the number of sessions attended, when X was last attended, or the outcome as there are no therapy notes. Additionally, there is no indication of a X. Considering the above factors, the medical necessity is not established.

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

Based on the entirety of the records, the claimant meets current clinical indications for X. The history documents X. Imaging of the cervical spine shows X. Conservative measures (X) have not resolved symptoms, and both the primary provider and treating neurosurgeon specifically requested X to determine whether the claimant's bilateral hand numbness and weakness arise from cervical radiculopathy versus peripheral neuropathies (e.g., carpal tunnel or ulnar neuropathy) in order to guide definitive treatment planning. These factors—X. Therefore, it is this reviewer's opinion that the services in dispute: X are medically necessary and the previous determinations are overturned.

Certified.

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
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE