PO Box 519
Schertz, TX 78154

IRO Certificate No: X

Notice of Workers' Compensation Independent Review Decision

Date of Notice: X

TX IRO Case #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]: This is a case of a now X who sustained a work-related injury on X. The mechanism of injury is detailed as an injury X. The diagnosis of the patient is cervical disc displacement, herniated nucleus pulposus of the cervical spine, decreased range of motion to the right shoulder, right infraspinatus tendon tear, pain radiating to the neck, tendinosis of the right shoulder and right arm weakness. No significant comorbid conditions were identified. Prior treatments included medications, X. According to the X, Progress Notes, X, M.D., the patient, presented a follow-up appointment due to pain and swelling in the arm & shoulder. On examination of the right shoulder, there was tenderness and swelling in the lateral portion of the shoulder. There was also a limited range of motion. Current medications listed were X. The neurological exam was X. On X, a request for X was denied as the records did not show the prior response to X, there were no palpated

trigger points on exam, and the records did not show the X. On X, the provider requested reconsideration of the X. The goal of the treatment is to provide pain relief, increase performance in the activities of daily living, and reduce the patient's symptoms as well as reduce medication usage. A request is noted for X.

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

The Official Disability Guidelines for X: X: Initial X for X: X. Physical examination identifies focal hypersensitive bundle or nodule of muscle fiber harder than normal consistency. X is used alongside X. X is performed using X. X.
Subsequent X for X: Focal area of pain in skeletal muscle has recurred. Patients have documented improvement in function after the most recent previous X. Patient reports ≥ X improvement in pain after most recent previous X. X is performed using X. X is NOT recommended for any of the following: X. The patient complained of ongoing

pain and the provider recommended X. However, in this case, there is no submitted documentation that the patient X. The patient has X. Myofascial pain is caused by a X. Therefore, the request for the X is denied as not medically necessary.

SOURCE OF REVIEW CRITERIA:

- ☐ 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 Judgment, Clinical Experience, and Expertise in Accordance with Accepted Medical Standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☒ ODG- Official Disability Guidelines & Treatment 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)

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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)

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A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: X