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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:

- Overturned (Disagree)
- Partially Overturned (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 on X. X reported X was X. The diagnoses were cervicalgia, radiculopathy, cervical region and carpal tunnel syndrome, left upper limb. On X, X was evaluated by X, NP, for a follow-up of cervical spine pain. X was status post X on X. X presented for evaluation and treatment of neck pain with radiation into the left upper extremity. X reported X was involved in an X. X was following up from an X. X reported it relieved X neck pain significantly about X, but it was slowly coming back. X was still feeling pain in X left arm and had significant weakness and numbness. X was barely able to lift an empty X gallon bucket with X left arm. Since X initial injury, X had been enrolled in X. X had completed X. X had also been utilizing X as needed. Despite the conservative care, X continued to have significant pain in X neck / left arm. X did have a X. Cervical spine examination revealed X. Motor exam showed X. Sensation was decreased to X. There was X was noted. Spurling's test was X. Left cervical facet loading test showed X. The range of motion was X. Treatment plan was to proceed with X. X-rays of the cervical spine dated X, revealed X. An MRI of the cervical spine without contrast dated X, revealed that at the X. At the X, there was a X. There was X. At the X, there was X. There was X. At the X. A X was noted, which may explain 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: "Regarding X notes that the X. Reason for testing is X. In this case, the medical records document symptomatology that is adequately explained by the MRI findings. There is no indication that the claimant X. Guidelines require X. Furthermore, the documentation does not support a X. As such the medical necessity of X is not established either. Recommendation is to deny the request. "Per a reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "ODG by MCG Last review/update date: X. ODG Criteria Reason for testing is X. Regarding this request, ODG notes that X. In this case, the medical records document X. There is no indication that the patient X. Guidelines require X is not established. Furthermore, the documentation does not support a X, as the physical exam from X does not document X. Therefore, the request for X is non-certified and upheld. "Based on the clinical information provided, the request for X is not recommended as medically necessary and the

previous non-certifications are upheld. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Regarding X. Reason for testing is X. In this case, the medical records document X. There is no X. Guidelines require X. Furthermore, the documentation does not support a X. As such the medical necessity of X is not established either. Recommendation is to deny the request." Per a reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "ODG by MCG Last review/update date: X. ODG Criteria Reason for testing is X. Regarding this request, ODG notes that X. In this case, the medical records document X. There is no X. Guidelines require X. Furthermore, the documentation does not support a X, as the physical exam from X does not document X. Therefore, the request for X is non-certified and upheld." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is no indication of X. Cervical MRI notes X. On physical examination X. There is a X. The submitted clinical records indicate that the patient underwent X. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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:

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous non-certifications are upheld. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Regarding X, ODG notes that the X. Reason for testing is X. In this case, the medical records document X. There is no indication that the claimant X. Guidelines require X. Furthermore, the documentation does not support a X. As such the medical necessity of X. Recommendation is to deny the request." Per a reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "ODG by MCG Last review/update date: X. ODG Criteria Reason for testing is X. Regarding this request, ODG notes that X. In this case, the medical records document X. There is no indication that the patient exhibited X. Guidelines require X. Furthermore, the documentation does not support X, as the physical

exam from X does not document X. Therefore, the request for X is non-certified and upheld.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is no indication of X. Cervical MRI notes that at X. On physical examination sensation was X. There is X. The submitted clinical records indicate that the patient underwent X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. 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:

- 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)**