



Physio Solutions LLC
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Notice of Independent Review Decision

IRO Reviewer Report

X

IRO Case Number: X

Description of the services in dispute

X

Description of the qualifications for each physician or health care provider who reviewed the decision

X

Review Outcome: Upheld

X Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

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

Summary:

X diagnosed with C4-5 spondylolisthesis, C4-5 disc protrusion, and C5-6 disc protrusion and seeking coverage for an X. The member X at work and reported neck and shoulder pain. The member was treated with X. No X records were included for review. The member was a X. The X was denied by utilization review as imaging X.

Per the X MRI of the Cervical Spine, the impression revealed X.

Per the X CT Cervical Spine, the impression revealed X.

Per the X X-ray of Cervical Spine, the impression revealed X.

Per the X Follow-up Note with X, MD, the member continues to experience significant discomfort following a work-related injury that occurred on X. In the member's own words, they describe persistent neck pain, rated between X and X out of X, and shoulder pain. They are unable to sleep comfortably due to the shoulder pain, leading to functional limitations that prevent them from returning to work. The member has previously undergone X, but they note that it has not provided significant relief. A focused physical examination reveals X. The range of motion for the cervical spine shows flexion to X degrees, extension to X degrees, lateral flexion to X degrees, and rotation to X degrees, all of which are limited and elicit pain. Special tests for shoulder impingement are X, and an assessment for cervical radiculopathy X results. The MRI scan of the cervical spine dated X, demonstrates a X. The member also presents with X. In summary, the provider's plan for the member moving forward emphasizes continued X. Given the findings of X. The member is advised to continue using X. Plans for further imaging studies may be necessary if the member's condition does not stabilize with ongoing treatment efforts.

Per the X Letter of Medical Necessity by X, MD, the appeal for the X. Despite undergoing X,

X continues to experience severe neck and bilateral shoulder pain. Diagnostic imaging, X. The attending physician, Dr. X, emphasizes that the recommended X is medically necessary to prevent potential permanent harm, including neurological damage, which could result from further delays in treatment. The appeal highlights the urgency of addressing X deteriorating condition to ensure X health and well-being.

Per the X Follow-up Note with X, the note contained very similar information to the X visit summarized below.

Per the X Notification of Adverse Determination, X sent a letter to the member regarding the request for X. After review, the request for this procedure was denied as not medically necessary. The member did not meet the policy criteria for treatment outside of the Official Disability Guidelines (ODG), which requires pre-authorization and the demonstration of medical necessity based on accepted diagnoses.

Per the X Follow-up Note with X, MD, the member continues to experience significant complaints related to neck pain, bilateral shoulder pain, and low back pain. Subjectively, the member rates the neck pain as a X to X out of X, consistently worsening when looking up or side to side. The bilateral shoulder pain, which is rated similarly, has persisted, contributing to an overall reduction in functional capacity. The member reports increased difficulties with daily activities, unable to return to work due to the severity of symptoms. The member expresses frustration with ongoing dizziness that affects balance and coordination when bending forward or changing positions in bed, leading to further limitations in mobility. Upon physical examination, there is observable stiffness in the cervical and thoracic regions, with restricted range of motion measurements. The cervical spine exhibits limited flexion to X degrees (normal being X degrees), extension to X degrees (normal being X degrees), and rotation to the left and right both at X degrees (normal being X degrees). Neurological examination findings present X. Special tests performed include the Spurling's test, which X. The Neer and Hawkins-Kennedy tests for shoulder impingement were X, causing significant pain during both maneuvers, further indicating a possible X. Diagnostic imaging performed earlier includes an MRI of the cervical spine, which demonstrates a X. The provider's plan for the member emphasizes a need for further comprehensive evaluations, X, which was unfortunately denied. A second appeal for the X has been submitted, awaiting a decision. Meanwhile, the provider recommends continued X. The importance of monitoring daily activities to prevent exacerbation of symptoms is reinforced. A X is X.

Per the Notice of Appeal Adverse Determination X, X sent a letter to the member regarding the appeal for the request for X. After review, the request for this X was denied as not medically necessary. The member did not meet the policy criteria, specifically that the requested treatment is not considered appropriate based on the Official Disability Guidelines (ODG), and there was a lack of compelling clinical evidence to support the necessity of the X for the accepted compensable injuries.

Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision

After a review of the information provided for review, and the Official Disability Guidelines, the request for X is not supported as medically necessary. The ODG by MCG states that “X.” The records did not document the X. No X records for the member were included for review detailing response and lack of progress with treatment. Furthermore, the current evaluation of the member did not detail any X. Therefore, medical necessity is not established for the service in dispute. I recommend the previous denial remain upheld and the request for X be denied.

Description and source of the screening criteria or other clinical basis used to make the decision

ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase

AHRQ - Agency for Healthcare Research and 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

X 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)