

**Clear Resolutions Inc.  
An Independent Review Organization  
3616 Far West Blvd Ste 117-501 CR  
Austin, TX 78731  
Phone: (512) 879-6370  
Fax: (512) 572-0836  
Email: [@cri-iro.com](mailto:@cri-iro.com)**

***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 at work on X. The mechanism of injury was not documented in the available medical records. The diagnoses were cervical radiculopathy, herniated disc at the X level with myelopathy and herniated disc at the X level with myelopathy. On X, X was seen by X, MD, for follow-up evaluation of neck and shoulder pain. X had new onset of neck pain that radiating to X right shoulder and arm. X had numbness to X hand. X had to hold X right arm flexed against X chest for relief. X had previous X. X had not had any issues of note since X until about X months prior. On examination, weight was 295 pounds and body mass index (BMI) was 49.09 kg/m<sup>2</sup>. The examination of the neck revealed it was X. There was X. Neurological examination showed X. The sensory examination showed neck pain radiating to the right shoulder; it was aching, numbness, and pins and needles sensation of the right shoulder more to the right with numbness X of the cervical spine were noted. Treatment plan was X. X would require X prior to any X. Per an office note dated X completed by an unknown provider, X presented for evaluation of X ongoing complaints of right shoulder and neck pain since the prior X months. X complained of right shoulder pain radiating down the right arm to the hand and had numbness to the hand. X had to hold X right arm flexed against X chest for relief. X was status X. X was feeling well until X-months prior. The symptoms were reproducible. Sensation was X. X had neck pain to bilateral shoulders, aching, numbness, pins-and-needles from right shoulder down the arm to the right wrist / hand with numbness. X was noted, with tightness, decreased range of motion of the hand and paraspinal region. X-rays and MRI of the cervical spine dated X were reviewed. The treatment plan included X. On X, X was seen by an unknown provider at X for physical therapy initial evaluation. X

presented with ongoing complaints of shoulder and neck pain. X reported X pain was random, and X never knew when it would happen, but it occurred multiple times a day. X also got severe dizziness and took X. X was unable to lie on the right side and unable to lie flat due to neck pain. That day, neck disability index was X - showed X. On cervical spine examination, the range of motion showed flexion was X degrees with pain in the cervical spine, extension X degrees with pain in the cervical spine and increase in numbness and tingling, right rotation was X degrees with pain, left rotation was X degrees with tightness, right side bending was X degrees with pain and left side bending was X degrees. The right shoulder flexion was X degrees and "feels tight" with active range of motion. The strength was X flexion, extension, right and left side bending with pain. X posture was observed as forward head. Light touch sensation was intact to bilateral upper extremities (UEs); however, X reported right arm sensation was diminished compared to the left upper extremity (LUE). X was unable to touch as the cervical spine musculature was with severe neck pain, bilaterally. It was noted X had a history of cervical spine injury at work and presented with cervical spine pain, decreased cervical spine range of motion (ROM), decreased cervical spine strength, and decreased bilateral upper extremity (UE) strength affecting X ability to perform activities of daily living (ADLs) and functional activities. An MRI of cervical spine dated X revealed the following findings: There was some X. X hardware was again noted at X. X through the disc spaces demonstrated the following: At the X, there was narrowing of the X. At the X, there was X. At the X, there was X. There was X. At the X, there was X. There was least moderate X. At the X, there was X was noted. At the X, there was X. There was moderate to severe X. X was recommended. The impression of the study noted there were X. Treatment to date included X. Per a utilization review adverse determination letter dated X, and a peer review report dated X, the request for X was denied by X, MD. Rationale for denial of X: "The request is not medically necessary. The records did not document X.

Recent use of X for pain was not detailed. The records did not include a current clinical assessment of the claimant. The prior evaluation was more than X months old and is out of date. Given these issues which do not meet guideline recommendations, this reviewer cannot recommend certification for the request. Therefore, the request is not medically necessary.” Rationale for X: “The request is not medically necessary. As the X request is not indicated, there would be no requirement for X. Therefore, the request is not medically necessary. In a letter dated X, X, MD, documented that X lived too far away to come back to office, a several-hour drive. X had tried X, but was unable to tolerate it due to pain. X symptoms were worsening (worsening arm / shoulder pain since the prior visit). The neck pain went into shoulder / arm, and X had to put the arm above the head for relief (correlated with imaging). X was unable to do activities of daily living because of symptoms, such as washing dishes, dressing, etc. X was a X. At the time, X had X. X had X. Dr. X would resubmit for reconsideration per X request. Per a reconsideration review adverse determination letter and a peer review report dated X, the request for X was denied by X, MD. Rationale for denial of X: “In this case, the requested X is not medically necessary. There is insufficient documentation to demonstrate that the patient has X note has been submitted for review, which was the initial evaluation. Furthermore, there are no examination findings that would support the requested procedure. Thus, the guidelines have not been met. Therefore, the stat requested appeal for X is upheld and non-certified.” Rationale for X: “Guidelines do not pertain, as the primary X is not supported. As the X request is not medically necessary, the X requests are not indicated. Therefore, the stat requested appeal for X is upheld and non-certified. “The claimant has a prior history of a X. The claimant had continued to report neck and upper extremities pain despite prior X. The claimant had used X. The cervical MRI report did note at X. The claimant’s physical exam findings still noted X. Given that the claimant has X to date for ongoing cervical radiculopathy, it would be appropriate

to proceed with X which would require X. X would be appropriate in order to rule out any risk factors for X. Therefore, in this reviewer's opinion medical necessity is established for the service in dispute which includes X. The prior denials are overturned. X is medically necessary and certified

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

The claimant has a X. The claimant had continued to report neck and upper extremities pain despite X. The claimant had X. The cervical MRI report did note at least X. The claimant's physical exam findings still noted X. Given that the claimant has X. X would be appropriate in order to rule out any risk factors for X. Therefore, in this reviewer's opinion medical necessity is established for the service in dispute which includes X. The prior denials are overturned. X is medically necessary and certified

Overturned

**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)**