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***Notice of Independent Review Decision
Amendment X***

IRO REVIEWER REPORT

Date: X:Admendment 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 Overtuned (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. Mechanism of injury was not provided in the available medical records. The diagnosis was cervical radiculopathy. No office visit notes or current imaging was available for review. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Regarding X. An X may be indicated when all criteria are met, such as the presence of X. There must also be the existence of diagnostic imaging like a CT scan or MRI that correlates with the symptoms. Also, the X. Moreover, the claimant must have failed to respond to more than X weeks of X. An X is clinically appropriate if it is their X. Also, the pain must cause the claimant functional disability, they have had less than X. X are not recommended for X. The request is not supported based on the submitted documentation. The referenced guidelines recommend X. It also stated X. In this case, the claimant was diagnosed with cervical radiculopathy, and the imaging findings were consistent with the diagnosis. They have chronic severe pain with numbness, tenderness, and dysesthesia extending to the left upper extremity, and a positive Spurling’s test was noted on the left side. Despite X, the claimant’s condition has not improved. The request does not align with the guidelines and is not medically necessary, as X. As such, the prospective request for X is non-certified. “Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Regarding X. The cited guidelines further state that diagnostic imaging like an MRI should correlate with the symptoms and X. Moreover, there should be a failure to respond to X. Treatment is also clinically appropriate for an X. The cited guidelines also require the procedure to be performed under fluoroscopy or CT guidance with no

bleeding or clotting disorder and no local or systemic infection. Additionally, the cited guidelines do not recommend performing it at levels above X. Per the submitted documentation, the request is not warranted. The referenced guidelines recommend X. There should be a failure to respond to X. Furthermore, an X. Additionally, it is not recommended to be performed at X. A prior review for X. The claimant had neck pain with numbness extending to the left shoulder blade and arm and positive Spurling's test on the left side with tenderness and dysesthesia into the left upper extremity. Their treatment plan was for a X. Their MRI showed X. They had prior treatments with X which were tried and failed. However, the request was for a X. The request is not congruent with guideline criteria and there were no extenuating circumstances to warrant a deviation from guideline recommendations. Therefore, the prospective appeal request for X is non-certified. "Thoroughly reviewed provided records including provider notes, imaging findings, and peer reviews. The patient has pain in potentially radicular distribution corresponding to X. Imaging findings with MRI does show some findings which could explain patient's pain issues. While the cited guidelines do not recommend X above X. : Prospective request for X is medically necessary and certified.

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

Thoroughly reviewed provided records including provider notes, imaging findings, and peer reviews. The patient has pain in potentially radicular distribution corresponding to X. Imaging findings with MRI does show some findings which could explain patient's pain issues. While the cited guidelines do not recommend X is warranted as variance to guidelines. : Prospective request for 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)**