

**Maximus Federal Services, Inc.**  
**807 S. Jackson Road., Suite B**  
**Pharr, TX 78577**  
**Tel: 956-588-2900 ♦ Fax: 1-877-380-6702**

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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** 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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. X

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This case concerns a X who sustained a work-related injury on X. The member has been given a diagnosis of cervical radiculopathy. Magnetic resonance imaging (MRI) of the member's X on X noted X. A X progress note indicated that the member had neck and left shoulder pain. The physical examination at this visit noted that there was X. The plan included a X, which was done on X.

A X progress note indicated that the member obtained X percent (%) relief in the neck, but X left shoulder was "still pretty bad". The member complained of neck pain at this visit and the physical examination noted that there was X. The plan included a X.

The X progress note stated that X member had neck and left arm pain. The physical examination noted that there was X. The progress note stated that the X did not last. The plan included a X.

A X progress note stated that the member had neck pain that went into X left arm. The physical examination at this visit noted that there was X. The neurological examination noted that the X. The member reported that X had pain in X left shoulder and decreased range of motion in X left shoulder. The plan at this visit included another X.

The X progress note indicated that the member was taking X, X and X. It indicated that the member had neck and left arm pain and that X underwent X. The physical examination provided for review did not show results from the neck. The plan included X. A addendum to this record dated X noted that the X.

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

The Official Disability Guidelines & Treatment Guidelines (ODG) regarding X, state that “X. X by history (eg, radiation of pain and numbness along the distribution of the affected X. Repeat X in patient with good response to X, as indicated by ALL of the following: Documentation of sustained improvement of pain or function of  $\geq$  X%, as measured from baseline, for  $\geq$  X weeks after X.” The ODG also state that “Restoration of function should be the primary measure of treatment success. Functional improvement measures should be used over the course of treatment to demonstrate progress in return to functionality and to justify further use of ongoing treatment methods.”

The Maximus physician consultant indicated that within the documentation available for review, there is no documentation of the specific radiation of pain and numbness along the distribution of the affected X in any of the actual physical examinations to corroborate the radicular pain. The Maximus physician consultant also indicated that the addendum to the notes stating that the member’s pain relief was for almost X months over X months is not corroborated in the notes after the X. The Maximus physician consultant explained that as the plan X weeks after the X was to do another X, there is no baseline pain noted to actually corroborate X pain relief, and the X was never noted to help or improve the arm pain, which would be the radicular pain the X was supposed to address. The Maximus physician consultant also explained that no objective functional improvement was noted from the X to warrant a X

Therefore, I have determined that a X is not medically necessary for treatment of this member’s condition.

**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
- 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES:  
EPIDERAM CORTICOSTEROID INJECTION  
FUNCTIONAL IMPROVEMENT MEASURES FOR NECK AND UPPER BACK CONDITIONS
- PRESSLEY 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)**