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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 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 is a X who was injured on X, which was actually the result of a X. X had to X. At times, the X would X. As a result of that, X developed pain in the left shoulder as well as numbness in the left hand and pain in the back of the arm. The diagnosis was left brachial plexopathy. On X, X presented to X, MD, for follow-up evaluation. X stated that overall, X continued to do the same with some more pain because X had been rationing X medications because X had been losing all the appeals on X medications. X continued with shoulder pain and X pain level was about a X. X medication continued to help when X was able to take them and X had no issues with them. X presented for refill of X medications with two refills and then Dr. X would see X back in X months. Left shoulder examination was essentially unchanged as follows: There was mild tenderness to palpation diffusely, with tenderness also noted in the left upper trapezius musculature. There was discomfort with impingement test. There was weakness with supraspinatus test of the left shoulder. Left shoulder range of motion showed forward flexion of X degrees, abduction of X degrees, external rotation of X degrees, and internal rotation of X degrees. X still could not actively lift X arm above X degrees. Motor examination revealed left shoulder abduction at X. Reflexes were symmetrical at trace to X in the biceps and brachioradialis bilaterally and X triceps bilaterally. The assessment was left brachial plexopathy. X was to continue X. X was given a X. Treatment to date included X. Per a utilization review adverse determination letter dated X and a peer review report dated X by X, DO, the request for X was denied as not medically necessary. Rationale: "The. While the claimant has a left brachial plexopathy and dysfunction, the X. There was no mention of a single device. Given the claimant's

circumstances, and the guidelines, there is no support for the requested supplies. Therefore, the request for are not medically necessary.” Per a reconsideration review adverse determination letter and a peer review report dated by, MD, the appeal request for X was denied. Rationale: “ODG by MCG does not address the request X. Alternate chapter cited: ODG by MCG Last X" A previous utilization review dated X was non-certified on the basis of "The X device is a combination of X. While the claimant has a left brachial plexopathy and dysfunction, X are not supported based on the guidelines. There was no mention of X being tried with outcomes established. Given the claimant’s circumstances, and the guidelines, there is no support for the requested supplies. Therefore, the request for X are not medically necessary" According to guidelines, an X is not recommended for X. It is not advised as a X. Given that this is not a recommended treatment, the request is not medically necessary. Therefore, the request for X is upheld and non-certified.” Thoroughly reviewed provided records including provider notes and peer reviews. The ODG recommendations state that X are not recommended as a X. The ODG recommendations states X. The claimant has left shoulder pain and numbness in the left hand that have been treated with X. Musculoskeletal pain issues are not normally responsive to X. Further, it is unclear why the claimant needs X, and not a single modality alone. Therefore, the request for X are not medically necessary and non-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 and peer reviews. The ODG recommendations state that X. The ODG recommendations states X. The claimant has left shoulder pain and

numbness in the left hand that have been treated with X. Musculoskeletal pain issues are not normally responsive to X. Further, it is unclear why the claimant needs X. Therefore, the request for X are 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)**