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Notice of Independent Review Decision

Amendment X

IRO REVIEWER REPORT

Date:X; Amendment 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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. Mechanism of injury was not documented in given medical records. The diagnoses were post-cervical laminectomy pain syndrome with recurrent left cervical radiculopathy following previous surgical rehabilitative and medical treatment options for work injury and secondary myofascial pain syndrome of the neck and upper back area. On X, X was seen by X, DO for follow-up visit. X continued to have X. X were noted once again in X trapezius, interscapular, and posterior cervical regions. These were quiet "jump signs." This was non-radicular symptom. This was not radiating pain from a nerve root. This was myofascial pain associated with X neck injuries. Further delays in this treatment would lead to refractory and costly pain complaints. Dr. X stated that they were X. The X supported intervention in lieu of the X. This had been their experience with X. X was already on X. X took X at night for associated spasms, and X to help X. Avoiding heavy lifting, bending, or twisting in the meantime was advised. Continued active X modalities were suggested. X consulted X, DO on X for a follow-up. X continued to suffer from X. X had some X in X X. While X was getting improvement of pain relief in combination of X at night and X for associated spasms, X wanted to have something done. X wanted to proceed with X at the first trial. X were X. These were X noted. X would be scheduled for that pending insurance authorization. On X, X was seen by X, DO for initial evaluation. X presented with chief complaint of chronic neck pain, shoulder, arm and hand pain with associated numbness, weakness and tingling following a longstanding injury while at work. X pain has returned to X to X radiating primarily into X left arm and hand associated with numbness, weakness and tingling. The best relief, however noted was X, which was done in X with good more than X pain relief, improved function and range of motion. X presented for asking for this procedure. Physical examination revealed decreased neck range of motion and marked X. X had decreased X on the left. X had X. X were noted in the neck and upper back area. Decreased X on the left was noted with decreased rotation X degrees to the left and X degrees on the right. Treatment plan included X. Treatment to date included X. On X, Dr. X provided a letter indicating the description of the request as X. Dr. X stated that X was having X. “X” were elicited on that day. Per a utilization review adverse determination letter and peer review report dated X by X, MD, the request for X was denied. Rationale: “According to guidelines, X are not recommended in the absence of X. When this treatment is indicated, studies have not effectively demonstrated that ultrasound guidance for X. The effectiveness of X remains uncertain in part due to the difficulty of demonstrating

the advantages of active medication over X. X alone may be responsible for some of the therapeutic response. The only indication with some positive data is X , and this treatment may be appropriate when X are present for examination. X are not recommended when there are radicular signs. Documentation in this case is poor in supporting distinct X are not medically necessary. "On X, Dr. X provided a letter indicating the description of the request as X. Dr. X stated that X was having X were noted once again in X. There were quite "X" elicited on that day.Per a reconsideration review adverse determination letter and peer review report dated X by X, DO, the request for X was denied. Rationale: "The AP saw X in X and noted X had X. ODG does not support X for chronic neck/back pain and X injury is chronic. The AP requested X but did not indicate what medication X wanted to X. ODG does not support any medication other than local anesthetic be X. Therefore medical necessity is not established. "Thoroughly reviewed provided documentation including peer reviews. Dr. X identified X on X examination. Peer reviewers had issue with documentation and cited ODG criteria. However, given that patient has X that can potentially respond to X, requested X are indicated. Peer reviews were ambiguous about their issues with documentation and had questionable basis for interpretation of X which were outside the cited guidelines. 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 documentation including peer reviews. Dr. X identified X on X examination. Peer reviewers had issue with documentation and cited ODG criteria. However, given that patient has X that can potentially respond to X, requested X are indicated. Peer reviews were ambiguous about their issues with documentation and had questionable basis for interpretation of X which were outside the cited guidelines. 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

☐ 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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL