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Notice of Independent Review Decision

SENT TO: Texas Department of Insurance
Managed Care Quality Assurance Office
(MCQA) MC 103-5A Via E-mail
IRODecisions@tdi.texas.gov

DATE NOTICE SENT TO ALL PARTIES: 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

X

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a X who sustained an industrial injury on X and is seeking authorization for X. A review of the medical records indicates that the injured worker is undergoing treatment for X. X-rays of the cervical spine dated X have X.

X-rays of the cervical spine dated X have impressions of X. MRI of the cervical spine dated X has findings of X.

MRI of the cervical spine dated X has findings of X.

X-rays of the cervical spine dated X have findings of X. CT Myelography of the cervical spine dated X has findings of X. Previous treatment has included X, Previous surgeries included X.

Office visit dated X has the injured worker with sharp neck pain that radiates to the left upper extremity from the elbow to the hand. X has weakness on the left upper extremity. X is in physical therapy. The pain is rated at X. The examination and treatment plan are not clearly documented. Office visit dated X has the injured worker with a history of neck pain. The exam reveals decreased X. There is decreased X. There is X. X is X. The treatment plan included X. Office visit dated X has the injured worker X. The exam reveals he appears to be in discomfort. There is X. There is a limited X. The treatment plan included updated imaging including X.

Office visit dated X has the injured worker questioning if the X. X has pain that radiates into X upper extremities. The exam reveals a limited X. X are X. The treatment plan included a X. Office visit dated X has the injured worker noting some X.) X presented to the X last night and received a X. The treatment plan included X. Office visit dated X has the injured worker being X. The X continues to be beneficial for X low back and leg pain, however X continues to have right occipital, right shoulder, and radiating pain to the right biceps. The pain is electrical, burning, and shocking sensation. The treatment plan included a X. Office visit dated X has the injured worker with neck and upper extremity pain. X has a history of X. The exam reveals a pain level of X in the arm. The treatment plan included starting X.

Office visit dated X has the injured worker with persistent neck and back pain. The exam reveals a X. X are X. The treatment plan included right-sided X. Office Visit dated X has the injured worker with sharp neck pain. The pain radiates to the right shoulder with shocking pain at times. X wishes to consider surgical intervention, and this was discussed. The utilization review dated X non-certified the requested X. The rationale stated that while the claimant had X. A prior request for this procedure was non-certified on X for the same rationale.

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

As per ODG, “(X)X”

This is a X sustained an industrial injury on X, is seeking authorization for X. X presented on X with persistent neck and back pain. The exam reveals a X. X are X. X has X on

X. The current examinations do not X. However, the provided diagnostic imaging studies including the X.

Therefore, the X is medically reasonable and necessary based on ODG guidelines.

**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**
- 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)**