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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 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 while working when X. The diagnosis was cervical stenosis, status post anterior cervical discectomy and fusion (ACDF), cervical spinal stenosis, and cervical radicular pain. A progress noted dated X by X, MD was documented. X presented to discuss test results. X had a history of X. Previous symptoms included worsened bilateral hand numbness and pain to the thumb and index finger that radiated up to the elbow. The ongoing symptoms were same as before. X also complained of neck stiffness, frequent headaches and bilateral shoulder pain. The CT scan and MRI from X were reviewed. The cervical x-rays from X revealed X. The MRI from X . Soft tissue injury of the X was not excluded, although a X was not seen. X was noted within the X. X was most pronounced at X. Examination noted X. Reflexes were X. X was X. The assessment was X. X were started and X refilled. Exploration of previous X was recommended. A X was recommended, and X was to alternate X as needed. Per the physical therapy overview evaluation by X, PT, DPT /X, MD on X, X presented with a history of status post X, completed on X. X reported that afterwards, X was provided an X. X stated the left upper extremity would have cramping so severe, X had to pull X fingers apart with simple lifting activities such as X coffee. X stated X had new imaging completed that indicated severe X." X stated X trialed different medications with only mild improvement noted. X was now being referred for X. X rated pain a X at the time, X at its worst, and X at its best. X stated pain increased with prolonged sitting greater than X minutes, lifting / pushing / pulling, reading, and looking down or up. X

reported daily headaches X times a day that improved with X. X stated the pain improved with activity. It was located in the lower cervical spine all across, then intermittent nerve pain from the hands up to the elbows. X stated X always felt nerve pain in bilateral dorsal hands into all fingers. X reported numbness and tingling in the tips of the fingers with tingling of the remainder of the hand. Examination noted X. The thoracic spine range of motion was within X. It was noted that physical therapy evaluation revealed X. X also completed X. X did not respond to treatment on that date with X. X stated to physical therapist that X would like to hold on any further services at the time as X would like to proceed with X. Therefore, due to lack of ability to make any changes during evaluation and X recommended referral back to MD with no skilled services required at the time. An MRI of the cervical spine dated X, identified X. At the X, there was a X. At the X, there was X. There was X. At the X, there was X. At the X, there was X. At the X, there was X. A CT scan of the cervical spine dated X revealed X. There was X. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced below, this request is Non-certified. As per ODG, this is indicated for X. As per the office visit note dated X, the claimant had a follow-up to discuss test results. Previous symptoms included worsened bilateral hand numbness and pain to the thumb and index fingers that radiated up to the elbow. Current symptoms included some mild tingling in X fingers bilaterally with complaints of neck stiffness, frequent headaches, and bilateral shoulder pain. X had not identified any alleviating factors. X reported undergoing no recent treatment for the symptoms described. X medications included X. On review of systems, X complained of limited motion and pain. On physical examination, reflexes were X. X was X. X were within X. However, there was no documentation as there were no

physical therapy reports submitted that will document failure of treatment. Also, there is no clinical documentation to suggest the claimant had X. Guidelines criteria mentioned above are not met. Hence, the X request is not medically established. “Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced below, this request is not certified. There is no X. There is no evidence on CT scan of X. The proposed procedure is not indicated as there are minimal findings at X. “The requested surgical procedure is not medically necessary. The submitted imaging report does not demonstrate X. No new information has been provided which would overturn the previous denials. X is not medically necessary and non certified

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

The requested surgical procedure is not medically necessary. The submitted imaging report X. No new information has been provided which would overturn the previous denials. X is 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

☐ 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