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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 at work on X. X stepped from the X. X fell "face" forward, not sure if X head hit the deck, but with the right side of X body taking the first hit. X reported X palm, elbow, shoulder, and knee hit. X had an object puncture X right buttock. The diagnosis was cervical sprain / strain. On X, X was seen by X, MD, for initial visit for neck and back pain. X was not working. X underwent neck surgery early in X. X complained of neck and back pain, rated X. X was unable to work and felt dull, burning, pins and needles, numb and tingling. It did not exist prior to this injury. As far as the pain, the pain radiated but was mainly axial and constant. It was worsened by lying down, sitting a long time. The pain was constant; nothing really helped. X received X. X had X. The X were given but none of this really helped. X did have an MRI recently of the cervical spine and long-term of the lumbar spine. X had an X was noted in all these MRI. X saw Dr. X, neurosurgeon. X worked as a X, which involved all the duties of a X. Musculoskeletal examination revealed toe and heel walking was good. Examination of lumbosacral spine revealed flexion, extension, rotation of lumbosacral spine was decreased about X in all planes. Examination of cervical spine revealed decreased range of motion in flexion, extension, and rotation of cervical spine by X in all planes. Motor strength appeared to be X bilaterally in the upper extremity. The treatment plan was to proceed with X. Due to lack of improvement with conservative treatment, at that time in the treatment plan. Dr. X felt that X would benefit from X. The procedure was necessary to identify the pain generators and to relieve pain so that X could participate in a higher level and more meaningful rehabilitation program with the hope of returning to the former employment or continue with the ongoing employment either modified or regular work. On X, X was seen by X for a follow-up visit. X felt worse, dull, burning, like a pins and needles. X complained of low back pain radiating in the left lower extremity, rated pain as X. It was made worse by lying down, activity and better by heating pad. X reported new symptoms, especially of shoulder pain, left lower extremity pain and back pain. X was following the treatment plan, but it was not helping. X was taking X. X had received X. Of note, X had been denied X on the left. X had an MRI of the cervical spine, but of note, X had not had MRI of the lumbosacral spine. However, X had been considered as part of X injury of lumbar strain. On examination, vital signs were stable. X showed toe and heel walking was poor on the left. Examination of lumbosacral spine revealed flexion, extension, and rotation of lumbosacral spine

was decreased about X in all planes. X straight leg raise test was seen on the left with decreased dermatomal sensation on the left X. Paravertebral spasms seen at the X. Examination of cervical spine revealed paravertebral spasms bilaterally at X. Range of motion of the cervical spine was decreased in flexion, extension, and rotation of the cervical spine by X in all planes. Dr. X appealed the denial of the X. On X, X presented to Dr. X for a follow-up visit. X felt worse, sharp, burning, pins and needles, numb and tingling, rated X to X pain. X was able to do about X of X job, with constant pain. Sitting made the pain worse. Laying down and recliner made it better. X continued to have neck and back pain. X was following treatment plan, but was not helping. X was taking X which was not really helping a lot. X had X which had not helped. As far as procedures, X had been denied X. X continued to complain of low back pain. An MRI was performed which showed X. On examination, toe and heel walking was good. Flexion, extension and rotation of the lumbosacral spine was decreased by X in all planes. There were paravertebral spasms at X. There were paravertebral spasms in the X. Range of motion of the cervical spine was decreased by X in all planes. Treatment plan remained unchanged An MRI of the cervical spine dated X revealed X. Status post X. Multilevel degenerative changes result most prominently in moderate-to-severe X. An x-rays of the cervical spine dated X revealed X. There were X on the right seen. Moderate, marked X. There was X. The soft tissues seen, had limited evaluation. Treatment to date included X. Per a peer review report dated X by X, MD, the request for X was denied. Rationale: “Per ODG regarding X. "X. only to be considered for extreme patient X." There is no record of X in this case. The records show that X. The request is not shown to be medically necessary. Therefore, the request for a X is non-certified. “Per a utilization review adverse determination letter dated X, the request for X was non-certified. Rationale: “After peer review of the medical information presented and / or discussion with the contracted Physician Advisor and the medical provider, it has been determined that the health care service(s) requested does not meet the established standards of medical necessity. “On X, Dr. X placed an appeal for denial of X. Per a reconsideration / utilization review adverse determination letter/ peer review report dated X by X, DO, the appeal request for X was denied. Rationale: “Based on the documentation provided in per the guidelines, the requested X is not considered medically necessary at this time. Though the claimant continues to have neck pain secondary to work related injury, there

were X. Therefore, the request for Appeal: X is not medically necessary.
"Thoroughly reviewed provided records including peer reviews. The patient has pain in neck and lower back and the physician is attributing X neck pain to facet arthropathy. X has X. Based on X presentation and prior surgical correction, it is reasonable that X pain could be X. Request for X are thus warranted. However, as initial peer review points out, there is not a great deal of X. Thus, request for X is not warranted. X is medically necessary and certified. 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:

Thoroughly reviewed provided records including peer reviews. The patient has pain in neck and lower back and the physician is attributing X neck pain to facet arthropathy. X has X. Based on X presentation and prior surgical correction, it is reasonable that X pain could be mediated by X. Request X are thus warranted. However, as initial peer review points out, there is not a great deal of procedural X. Thus, request for X is not warranted. X is medically necessary and certified. X is not medically necessary and non certified.

Partially 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