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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. X tripped X. The diagnosis was sprain of ligaments of the cervical spine. X was seen by X, MD on X for complaints of neck pain. X was able to stand for more than X minutes and sit for more than X minutes. X was able to walk for more than X minutes. Pain level was X. The pain at the worst was rated X. The pain level at best was X. The pain was throbbing, burning and tingling down the right arm into fingers and stiffness. It was better with rest. Examination revealed no significant changes since the prior office visit.X visited Dr. X on X for complaints of neck pain. X was able to stand for more than X minutes and sit for more than X minutes. X was able to walk for more than X minutes. Pain level was X. The pain at the worst was rated X. The pain level at best was X. The pain was throbbing, burning and tingling down the right arm into fingers and stiffness. It was better with rest. Examination revealed no significant changes since the prior office visit. X was noted in the X. X had a follow-up with Dr. X on X for complaints of neck pain. X was able to stand for more than X minutes and sit for more than X minutes. X was able to walk for more than X minutes. Pain level was X. The pain at the worst was rated X. The pain level at best was X. The pain was throbbing, burning and tingling down the right arm into fingers. X stated being on the X. The pain was better with rest. There was improvement in overall pain by X. After the X , X was able to stand longer and sit longer. X was able to walk longer and sleep better. There was decrease in pain medicine. There was less stress. Side effects were not noted. X had pain again and would like another X. The prior lasted

one week and X had worsening pain at the time. Examination revealed no significant changes in the physical examination since the prior visit. The X was decreased while looking to the right. X were noted. X was noted in the X. A X on the right was requested. X communicated a willingness for anesthesia during the procedure. X had a degree of X. X understood that it was important to minimize sudden movement during the procedure. An MRI of the cervical spine dated X showed X. At the X, there was X. There was X. At the X, there was X. There was X. At the X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was non-certified. Rationale: “Regarding X. There should be the absence of X. The procedure should support an X. There should be failure of more than X. There should be X. In this case, the current plan of care does not include an evidence-X Considering this, the medical necessity of the request for X is not established. Recommendation is to deny. “Per a utilization review adverse determination letter dated X by X, MD, the request for X was non-certified. Rationale: “"ODG by X. Conflicting evidence, primarily observational, has challenged procedural efficacy, which is not without complication risks not recommended for the treatment of X. ODG Criteria for X." The patient is a X individual who sustained an injury on X. The patient was diagnosed with a sprain of ligaments of the cervical spine during the initial encounter. Prior treatments have included X. Per the office visit dated X, the patient reports neck pain rated X. Pain is described as burning and throbbing with tingling down the right arm physical exam documents facet tenderness on the left. Treatment plan is for X. In regards to this request, the patient had X on an office visit dated X, but the physical exam documents X. Physical exam is not consistent with the requested procedure. In addition, the current plan of care does not include an X. Therefore, the requested X, is upheld and non-certified.”The requested procedure is not medically necessary. The medical records that demonstrate the presence of radicular complaints. The guidelines do not support X in the presence of X. The medical

records do not demonstrate X. Furthermore, and evidence based rehabilitation plan has not been established. No new information has been provided which would overturn the previous denials. X in 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 procedure is not medically necessary. The medical records that demonstrate the presence of X. The guidelines do not support X in the presence of X. The medical records do not demonstrate X. Furthermore, and evidence based rehabilitation plan has not been established. No new information has been provided which would overturn the previous denials. X in 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