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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 at work while X. The diagnosis was chronic neck pain syndrome associated with right cervical radiculopathy, cervical disc disruption associated with chronic neck pain syndrome associated with right cervical radiculopathy, myofascial pain syndrome of the cervical, upper thoracic region. X, DO saw X in follow-up on X. X presented to discuss continued symptoms and treatment recommendations. The left neck pain and right shoulder pain was rated X. X had followed with Dr. X for pain management and Dr. X, the shoulder surgeon. Recommendations were reviewed. Dr. X noted they had received notification from Mr. X insurance company that only cervical strain and right shoulder strain were accepted diagnosis. Dr. X recommended a X and Dr. X recommended X. On examination, cervical range of motion showed right rotation X and left rotation X. There was tenderness at the left paraspinal muscles of the cervical spine. X was noted on the posterior and lateral left arm. Functional deficits included X. Right shoulder range of motion showed flexion X, abduction X, and internal rotation X. X was noted of the posterior and superior right trapezius / shoulder. Functional deficits included overhead tasks, reaching, and lifting. The following tests were positive: X test, X test, apprehension, and X test. A cervical spine X dated X was reviewed. An X of the right shoulder dated X was reviewed and revealed a X. The assessment was strain of neck muscle (disorder) and strain of shoulder muscle (disorder). It was noted that X was not at X. Work status was X. X was to continue the home exercise program, follow-up with Dr. X on X, and follow-up with Dr. X on X. X was continued. On X, X was evaluated by X, DO for follow-up for neck pain. X continued with moderate-to-severe neck pain following a traumatic work injury. Dr. X noted, “X is consistent with a X. Unfortunately, whoever reviewed this case does not realize the X. As a result, we are recommending a X. Once again, X has marked midcervical interspinous tenderness, pain with flexion. We do use a X. We went over X. We went over

attendant benefits and risks and complications. X is also incidentally being treated for a X. X continues with X. We discussed X. Once again, X had X. X is consistent with this injury, pain with flexion and we will go ahead and arrange for X. Any further delays in this treatment will only lead to more refractory and costly pain complaint." An X of the cervical spine dated X revealed there was X. There was milder disc dehydration from X. There was somewhat of a X. There was a right paracentral protrusion at X. This effaced the ventral subarachnoid space and slightly indented and deformed the ventral cord surface to the right of midline. Moderate X was present. There was X. There was X. There was at least X. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X MD, the request for X was denied. Rationale: "In this case, it is unclear why X is being requested. There is no documentation as to X. Therefore, the request for X is not medically necessary." Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X was denied. Rationale: "In this case, there is no record of current X. There is also no record of X. X is not recommended and there is no record of factors that would indicate such X. If "X " is all that is needed, the records do not explain X. The request is not shown to be medically supported. Therefore, the requested X is non-certified." The requested X is not medically necessary. The records do reflect the presence of X. The indication for X is not defined nor is it warranted based on the medical documentation. No new information has been submitted which would overturn the prior 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 X is not medically necessary. The records do reflect the presence of X. The indication for X. No new information has been submitted which would overturn the prior 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