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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 was trying to X. The diagnosis was cervicalgia, low back

pain, strain of muscle, fascia and tendon at neck level. On X, X evaluated by X, PT for physical therapy follow-up visit. X reported that X was trying to X. X had burning in shoulders that radiated to X tailbone. X did have X, which had resolved. X also felt like X was slightly out of it. At the time, X complained of pain in the neck, shoulders, and back, and dizziness / disorientation. X was able to perform activities of daily living slightly better in the morning. X was not able to perform housekeeping chores and had difficulty lifting X arm overhead. The symptoms improved when X was allowed to rest and had decreased sensory input. X had a pulling sensation in X shoulders that radiated to X neck, and this symptom was worse with activity. The Neck Disability Index score at the time was X, about X. On examination, cervical range of motion was reduced with forward bending X degrees, backward bending X, right and left rotation X degrees, and right and left side bending X degrees. Lumbar spine ROM showed X degrees flexion, X degrees extension, and left and right side bending X degrees. The left side bending was more painful than right. The bilateral upper and lower extremity strength was limited by cervical or lumbar pain. The sensation was diminished to sharp / dull on the left in the X. There was severe spasm present at the central cervical spine and bilateral upper trapezius. It was noted that X had made minimal improvements with pain control and motion in the cervical and lumbar spine. The symptoms of concussion continued to complicate normal activities of daily living (ADL) as well. X was advised to continue the present course to improve functionality. X was recommended X. Per the X visit note, it was noted that X had X. The upper trapezius (UT) / Levator stretch and manual soft tissue mobilization (STM) to the cervical spine reduced pain. X felt like the FDN performed that day was a slightly different technique than in the prior visit but was interested in determining if it helped. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Regarding X, the ODG recommends up to X visits of X. In this case, the claimant has completed X and it is not evident symptoms have improved. The claimant has pain, decreased cervical and lumbar motion and decreased function. There are no clinical findings provided on exam to indicate that X. The ODG notes that when treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. There is no indication of re-injury, exceptional factors or comorbidities noted as to why the claimant cannot continue with improvements in a home exercise program. Case discussed with PA who confirms that claimant has had extensive X. Claimant was seen in consultation, and X was recommended.

However, if after X there has been little or no meaningful improvement, and there are no new clinical findings, further therapy at this point would not appear medically reasonable. As such, there is no change in the recommended determination. “On X, an e-mail for appeal / reconsideration of X denied benefits was documented by X(Workers Compensation Coordinator) of X, stating, ”I have attached our records, X and progress notes along with what copies we obtained from Dr X office and the . MRI reports X and EMG report. It is our understanding that there are a few more tests that have not been approved and/or scheduled that were ordered by the neurologist. X next appointment with our office is X. These could be pertinent to X injury and treatment. New order for X has been written. Request X. The patient continues to have significant pain and additional X.” Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Based upon the medical documentation presently available for review, Official Disability Guidelines would not support a medical necessity for this specific request as submitted. As documented in the summary, previous treatment has included access to treatment in the form of an extensive amount of X services. The above-noted reference would support an expectation for an ability to perform a proper non-supervised rehabilitation regimen when an individual has received access to the amount of supervised rehabilitation services previously provided. As a result, presently, medical necessity for this specific request as submitted is not established for the described medical situation. This specific request would exceed what would be supported per criteria set forth by the above-noted reference for the described medical situation. Thoroughly reviewed provided records including peer reviews. Per ODG criteria utilized and cited by peer reviews, patient beyond normal recommended X amount for back and spine pain issues without major interventions. However, it is appropriate to have further X beyond guidelines when patient is making good progress towards functional goals or there are extenuating circumstances. Neither is present in the documentation for this patient thus further X not indicated. 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:

Per ODG criteria utilized and cited by peer reviews, patient beyond normal recommended X amount for back and spine pain issues without major interventions. However, it is appropriate to have X beyond guidelines when patient is making good

progress towards functional goals or there are extenuating circumstances. Neither is present in the documentation for this patient thus X not indicated. 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