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An Independent Review Organization
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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 worked for X. On X, while working and reaching up to retrieve a heavy (X-pound) package from the top shelf inside X package vehicle, X felt a pulling / burning sensation in X left neck that radiated down to X left shoulder blade area. The diagnoses were chronic neck pain syndrome with left cervical radiculopathy following work injury, cervical disc disruption with most notable disc disorder at X and X and myofascial pain syndrome of the cervical spine. On X, X was seen by X, DO, for follow-up visit. X was pleased to report more than X improvement, improved range of motion, and less radiating pain down X left arm and hand, which X stated at the time was completely resolved following a X. Due to X multilevel X. X denied any headache, fever or chills, numbness or weakness. X swelling as well had completely resolved. X as a repeated procedure should eliminate the remainder of X pain complaints. X still had some neck tightness particularly when looking left, and X were also noted. X did have pain with grip strength on the left with pain in the X. Dr. X recommended a X. X was using X occasionally, and X occasionally, and would arrange for this as soon as possible. X did well under minimal X. On X, X was seen by Dr. X for a follow-up visit. X received more than X improvement of X neck, shoulder, and arm pain. X felt X pain was starting to return, particularly in the right shoulder and upper back area. X did have pain radiating into X right arm, which had completely resolved following X. X received this care with no side effect. X stated X was not a X. They waited X to X weeks, and at the time, X wanted to X consistent with the ODG guidelines. Once again, X had a X, and decreased X. At the time, X rated pain X. X did use X. As a result, Dr. X recommended a X. They did receive this successfully,

utilizing X. X was X. X was showing good affect as X felt X was going to go on to a full recovery without surgical intervention and hopefully would arrange this as soon as possible. X prior to returning to work with Dr. X was advised. An MRI of cervical spine dated X revealed X. At the X level, there was a X. At X, there was a X. The X appeared acute or acutely irritated. There was X. At the 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, the records provided indicate that the injured worker recently received an X on X. X are supported by the guidelines if there is at least X relief sustained for a period of at least X weeks. As fewer than X weeks have elapsed since the X, the request for a X is not shown to be supported by the aforementioned guidelines nor otherwise medically necessary. As such, the request is noncertified. “Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X was denied. Rationale: “In this case, X is planned with X. Although a prior X was successful, ODG guidelines do not recommend X. The request is not shown to be medically necessary. Therefore, the appeal X is non-certified. “Thoroughly reviewed provided records including peer reviews. Provider states that X was successful that was performed on X. A successful X per ODG criteria would be X weeks with >X pain relief. Provider documents that patient had X weeks of pain relief. However, X weeks after X is X, which is in the future from the date that the provider last evaluated the patient X. Provider may have later evaluated the patient and noted the X weeks of pain relief but no documentation after X is provided. However, if this is the case, why is the provider already seeing another X within the X weeks while patient is supposedly still having pain relief? Given the blended timelines, X does not appear warranted based on supplied documentation. Further, no strong rationale is documented for why the patient requires X. 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. Provider states that X was successful that was performed on X. A successful X per ODG criteria would be X weeks with >X pain relief. Provider documents that patient had X weeks of pain relief. However, X weeks after X is X, which is in the future from the date that the provider last evaluated the patient X. Provider may have later evaluated the patient and noted the X weeks of pain relief but no documentation after X is provided. However, if this is the case, why is the provider already seeing another X within the X weeks while patient is supposedly still having pain relief? Given the blended timelines, X does not appear warranted based on supplied documentation. Further, no strong rationale is documented for why the patient requires 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