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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 Overtuned (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. The biomechanics of the injury was described as a motor vehicle accident. The diagnosis was cervical sprain / strain and lumbar sprain / strain. On X, X, MD evaluated X for a follow-up with respect to the work-related injury sustained while working for X. X felt about the same, X pain, unable to work, with constant pain. Activity made the pain worse. X was following the treatment plan; it was not helping. X has been taking medications which were prescribed, X. X had received X. X had no improvement with X. An MRI of cervical spine was obtained which showed X. On examination, flexion, extension and rotation of lumbosacral spine was decreased by X in all planes. X had paravertebral spasms in bilateral X medial branch facets as well as cervical decreased range of motion in flexion, extension, and rotation by X in all planes with left-sided X and X paravertebral spasms in the trapezius. X was recommended left X and X medial branch blocks. Due to lack of improvement with conservative treatment, at the 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, Dr. X evaluated X for a follow-up re-evaluation. X felt the pain, rated X. X was able to do about X of the job. X had constant pain. The pain was made worse by any activity and better by nothing. X was following treatment plan but was not helping. X did not state that X was taking any medications except at bedtime. X had received X. X had been denied for X on appeal. X had MRIs. On examination, flexion, extension and rotation of lumbosacral spine was decreased by X in all planes. X had paravertebral spasms at bilateral X and X. X also had paravertebral spasms in the cervical areas bilaterally on palpation with decreased range of motion of the cervical spine by X in all planes. Due to lack of improvement with conservative treatment, at that time in the treatment plan, Dr. X felt that X would benefit X. An appeal would be made for the denial of the X to IRO. An MRI of cervical spine dated X revealed there was X. At X, there was X was seen. AP dimension of the spinal canal was X. At X, there was X. X were narrowed,

left more than right. AP dimension of the spinal canal was X. X and X mildly contacted the X. Moderately severe left and moderate right X were noted. At X, X was shown. X, left more than right were seen. There was a X. Moderate X were seen. AP dimension of the X. The X was X. Severe left and mild right X was seen. At X, there was X. Spinal canal was X. X was contacted. At X, there was mild-to-X. The lateral recesses were X. AP dimension of the thecal sac was X. Ventral surface of the cord was equivocally contacted. Moderately severe X were seen, right greater than left. At X, there was X. AP dimension of the spinal canal was X mm at the midline. Left foramen 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: “ODG by MCG (www.mcg.com/odg), necessitates documentation of cervical pain that is non-radicular at no more than two levels bilaterally, X. The patient was diagnosed with a sprain of ligaments of the cervical spine and unspecified dorsalgia. Within the medical information available for review, there is documentation of a request for a X. Additionally, the (X) progress report identifies that conservative measures have failed to provide significant benefit. Also, there is documentation that a X is being considered. However, there is no clear evidence of any signs or symptoms to suggest that the patient has X. Therefore, the requested X is not medically necessary and is non-authorized. Per a reconsideration / utilization review adverse determination letter dated X, by X, MD, the request for X was not medically necessary. Rationale: “Official Disability Guidelines recommend X. On X, the claimant presented with constant pain. Pain level was X. Home exercise program has not helped X. X has not had any X. Cervical spine examination showed X. There is paravertebral spasm at X. Cervical Spine MRI showed X. A prior review dated X non-certified the request for X. In this case, the claimant's cervical MRI report showed X X. Guidelines do not recommend X. As such, the medical necessity has not been established for the Reconsideration Request for X.”As the patient has X. Therefore the requested 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:

As the patient has X. Therefore the requested 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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**