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Notice of Independent Review Decision

Amendment X

IRO REVIEWER REPORT

Date:X; Amendment 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. While X was lifting boxes X injured X left elbow and shoulder on X. The diagnosis included cervical sprain / strain and lumbar sprain / strain. On X, X presented to X, MD for complaints of head, neck, shoulder and low back pain since injury. Multiple heavy objects fell on X in X on X. X was not working. X was complaining of spine and left-sided pain, neck, headaches and low back pain radiating to both lower extremities since X. X was complaining of numbness in X hands, X pain. X was unable to work, did not exist prior to X injury. X pain radiated into the left lower extremity. X also had neck pain and headaches. X felt the pain constantly, any gripping made the pain worse. X had received multiple sessions of therapy without any improvement and home exercise program. X had no injections. X was supposed to get some kind of X, but apparently they did not get this approved or done. X had MRIs of the cervical spine, which showed X. X had left shoulder MRI, but not a right shoulder MRI. X stated that X had loss of consciousness at the time of the injury. X had not seen any other doctors. X worked in X. Examination showed X cervical range of motion was decreased by X to X in X. X also had poor toe and heel walking. Flexion, extension androtation of lumbosacral spine was decreased X. X had X. Positive X. X had X. X had decreased sensation in the left X. Good bilateral hand grip was noted. X was able to abduct both X arms to about X degrees. X stated X was unable to place X hands behind X neck. X was unable to place X hands behind X back. X and X was recommended. Individual therapy was encouraged. Due to lack of improvement with conservative treatment, at the time in the treatment plan, X would benefit from X. X

were recommended. If these were successful, X was recommended. On X, X was seen by Dr. X for re-evaluation of a work related injury sustained while working for X. on X. X rated X pain X. X was unable to work. Pain was made worse by any kind of movement. No movement made it better. X was following the treatment plan, which was not really helping. X had medications. X received therapy without any improvement. X had MRIs done, other workup done without any other issues. Examination showed cervical spine range of motion was decreased by X. The appeal outcome of X was pending. An x-ray of the left shoulder dated X showed normal left shoulder. An x-ray of the left elbow dated X demonstrated normal left elbow. An x-ray of the left wrist dated X revealed X abnormalities of the left wrist. An MRI of the cervical spine dated X revealed motion artifact affecting evaluation. Broad-based X was noted at X. There was X at X. The canal was X. Severe X. Moderate and X. There was no fracture. The cervical spinal cord was X. An MRI of the left shoulder dated X showed mild X. Treatment to date included X. Per a Peer Review Report dated X by X, MD, the request for X was denied. Rationale: “Within the documentation provided for review, the claimant has neck pain. The claimant has attempted physical therapy without improvement The physical exam notes tenderness and decreased range of motion. However, there are no objective findings of facet mediated pain such as positive facet loading maneuvers, in addition, there is no documentation of the intended levels for treatment Therefore, X is not medically necessary. “Per a Peer Review Report dated X by, the appeal request for X was not medically necessary. Rationale: “The previous denial documented that the physical exam noted tenderness and loss of motion, but no objective findings of facet mediated pain such as positive facet loading. Also, no documentation regarding intended levels for treatment. Updated note on X was provided for review. It was documented that the claimant had pain that was rated X, claimant was unable to continue working, and nothing

made pain better. All activities and movement would worsen pain. Claimant was on X which was helpful, has had PT without improvement, and active with home exercise without improvement. On examination range of motion was decreased by X. X bilaterally, and there were spasms noted throughout the X. ODG states that Diagnostic Facet Job Medial Branch Block (MBB) for Neck and Upper Back Conditions is recommended prior to considering X. Not recommended in the thoracic spine. A diagnostic X. No more than one set of X are not recommended. Criteria for X: Absence of radicular pain, spinal stenosis, previous fusion (same level), infection, tumor, coagulopathy, or anticipation of a surgical procedure; Documentation at least X months of X. In this case, the updated documentation provided no indication regarding levels for treatment, no documentation regarding levels were injection, and no evidence of facet mediated pain on objective examination. Therefore, the request for X is not medically necessary. “Thoroughly reviewed provided medical records including peer reviews. Provider has met criteria for request for X per the extensively cited ODG criteria. The patient has subjective pain in facet distribution, has tenderness to palpation with reproducible spasms around facets on objective exam, has completed conservative treatments extensively without success, and provider requesting X. While reviewers took issue with unclear which level of medial branch block planning to perform based on most recent progress note, the documented findings around X. X is medically necessary and certified

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Thoroughly reviewed provided medical records including peer reviews. Provider has met criteria for request for X per the extensively cited ODG criteria. The patient has subjective pain in facet distribution, has

tenderness to palpation with reproducible spasms around facets on objective exam, has completed conservative treatments extensively without success, and provider requesting X initially, but only one level appears requested. While reviewers took issue with unclear which level of X planning to perform based on most recent progress note, the documented findings around X. X is medically necessary and certified Overturned

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