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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)

Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured while at work on X, when X suffered an injury. X stated X. During treatment for the right knee injury, X had a X. This caused X to X. The diagnosis was cervical spondylosis, spinal stenosis in cervical region, and cervical radiculopathy. On X, X was seen in follow-up by X, MD. X had a history of a X on X and injured X right knee, neck, and back. During treatment for the right knee injury, X had a X. This caused X to fall from the examination table fracturing X tooth, causing a left knee meniscus injury, a closed head injury, and aggravating X neck and back pain. Review of an MRI of the cervical spine on X revealed X. Review of an MRI of the left knee dated X revealed X. Review of an MRI of the lumbar spine on X revealed X. At the time, X was status post lumbar surgery X. X reported X symptoms were largely unchanged. X continued to report pain at X neck, back, and right knee. X completed the diagnostic BUE EMG. X had the updated diagnostic cervical spine MRI scheduled for later that X. X was still awaiting the benefit review conference to appeal the denial for the requested X per Dr. X. X continued to see the pain specialist Dr. X. X also continued to see the mental health providers. X was still not working due to X injury. X denied any X. X denied any falls or new injury. X denied any complaints that day. On examination, X had an X. X had a significant amount of difficulty performing heel and toe walking and squatting unassisted. There was an X well-healed postsurgical scar noted at the lumbosacral midline. There was a X well-healed postsurgical scar noted at the anterior left knee and a X well-healed postsurgical scar noted at the anterior right knee. There is bilateral cervical paraspinal muscle spasm and tenderness noted at the cervical spine diffusely. There was decreased range of motion and pain with movement of the cervical spine in all planes. X muscle strength was noted at the bilateral biceps, otherwise X muscle strength in both upper extremities. Decreased pinch and grip strength was noted bilaterally. There was X noted diffusely. There was decreased X. Dr. X was unable to elicit a bilateral Achilles tendon reflex, X muscle strength noted at the bilateral knee flexors and left hip flexors, otherwise X muscle strength of both lower extremities. There was decreased range of motion and pain with movement at both knees. The assessment was lumbar spondylosis, cervical spondylosis, chondromalacia of left knee, synovial plica syndrome of right knee, synovitis of

joint of right knee, impaired cognition, post concussion syndrome, somatization disorder, spinal stenosis in cervical region, cervical radiculopathy, post laminectomy syndrome, and lumbar radiculopathy. Dr. X noted that X was temporarily totally disabled. X was scheduled for an updated cervical spine MRI on X. X was to follow-up with pain management as scheduled and continue the X. X was to continue X. Home exercise program and anti-inflammatory diet were recommended. X was still awaiting benefit review conference to appeal denial of the recommended X per the spine surgeon, Dr. X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD, as not medically necessary or appropriate. Rationale: "According to ODG, MRI of cervical spine is conditionally recommended if the individuals have cancer or neoplasm evaluation, infection, abnormality on neurologic examination. In this case, there is no documentation or of subjective complaints or radiculopathy or significant objective findings demonstrating nerve root compression. Although it is noted that the individual has aggravating back pain, there is no documentation of any ADL deficits demanding an MRI. Notably, the recent EMG revealed X; hence a need for an MRI is questionable. The medical report mentions that the individual is on medications and HEP and experienced persistent pain, but no documentation of PT sessions regarding frequency, duration, completion and outcomes. Hence the request is not medically necessary or appropriate and is denied. "In an undated appeal letter, X, MD wrote, "I have read the X opinion by Dr. X and X respectfully disagree with X. X have requested an updated diagnostic X for this patient because X continues to have significant pain at X cervical spine radiating into X bilateral upper extremities. The patient also continues to have weakness at X upper extremities that has been documented for multiple visits. Specifically, X has weakness at X bilateral biceps which is relevant for the X strength bilaterally, relevant for a X. Moreover, the aforementioned X BUE EMG suggested possible left and right X. X has had debilitating neck pain radiating into both upper extremities ever since X work injury. X denies any previous similar complaints. X requires monthly visits with a pain specialist for medication management to perform X activities of daily living such as Sleeping, walking, grooming and standing. X has been seen by a spine surgeon who has recommended surgical intervention for the X. The patient has already undergone numerous pain management interventions at the cervical spine which have not been helpful. The last cervical spine MRI was completed in X

and showed X. This patient is not at MMI. X continue to expect improvement with adequate treatment and I fear needless debility with treatment neglect. “Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD, as not medically necessary or appropriate. Rationale: “Official Disability Guidelines conditionally recommend cervical spine MRI as a first line or second line option for a variety of acute and chronic conditions including new neurologic abnormalities and new or progressive neck pain. Per this appeal review, this request was denied on X citing a lack of ADL deficits, significant objective findings, and details regarding PT. There is no new information to address the reasons for previous denial. There is no documentation regarding when previous injections were performed or their outcome or whether the individual has attended X and if so, the number of sessions or functional outcome. Furthermore, the objective findings are limited to tenderness, spasms, and X strength in bilateral biceps. There are no sensory deficits noted or red flag symptoms and no documentation of subjective complaints of radicular pain. In addition, a recent EMG of the BUE revealed possible X, hence, the need for an MRI is questionable. Considering the above facts, the medical necessity is not established. As such, the request is not medically necessary or appropriate and is denied. “Thoroughly reviewed provided records including provider notes, imaging findings, and peer reviews. Patient with chronic pain issues that may be evolving with newer symptoms involving bilateral upper extremity weakness related to cervical radiculopathy. While this radiculopathy was identified on NCS/EMG, there was no imaging consistent with these findings as last cervical MRI was in X. Thus, a request for X is warranted to guide further management. 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 records including provider notes, imaging findings, and peer reviews. Patient with chronic pain issues that may be evolving with newer symptoms involving bilateral upper extremity weakness related to cervical radiculopathy. While this radiculopathy was identified on NCS/EMG, there was no imaging consistent with these findings as last cervical MRI was in X. Thus, a request for X is warranted to guide further management. 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**
- ☒ **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)**