Becket Systems

Notice of Independent Review Decision

Case Number: X Date of Notice: X; Amendment X

Becket Systems
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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 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 is a X who was injured on X.

No medical records were available for review other than 2 utilization reviews.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, DO. Rationale: "The proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. Official Disability Guidelines recommend postoperative physical therapy. On X, the claimant underwent cervical discectomy on X; states is less sore today, pain rated 5-7/10. Cervical spine exam shows diminished range of motion and strength, numbness in lower extremity, occasional numbness and tingling in the upper extremity and right hand. Request exceeds guideline recommendations, and no extenuating factors were noted to warrant additional sessions. As such, the request for X is non-certified."

Per a utilization review adverse determination letter dated X, the reconsideration request for X was denied X, MD. Rationale: "The proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. The Official Disability Guidelines conditionally recommend therapeutic exercise for neck conditions when there is functional deficit noted. The claimant was seen for physical therapy visit and completed X. The claimant reported stiffness in the cervical spine. The claimant is s/p cervical discectomy at X on X. The claimant displayed more difficulty with standing abduction on left compared to right. The claimant left the session with less stiffness and improved gait presentation. Per physical therapy note dated X. Attention focused on improving right lower extremity functional strength and stability. The claimant continued to have deficit on the right lower extremity compared to the left lower extremity and required cueing to decrease compensation. Per physical therapy report dated X,

the cervical range of motion was forward 25 degrees, backwards 17 degrees, right rotation 45 degrees, and left rotation 30 degrees. There was numbness in the lower extremities and occasional numbness and tingling in the upper extremities and right hand. This request was previously reviewed and denied as the request exceeds guideline recommendations and no extenuating factors were noted to warrant additional sessions. There is documentation that the claimant has completed X and there is no clear objective documentation for functional improvement noted. Also, X exceed the guideline recommendation. Partial certification is not permitted in this jurisdiction without peer-to-peer discussion and agreement. As such, the request for X is noncertified.

Thoroughly reviewed provided records including peer reviews.

As reviews note, based on cited ODG criteria, patient may be X. While X may be warranted, no extenuating circumstances or objective functional performance has been documented to warrant X. X to the 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.

As reviews note, based on cited ODG criteria, patient may be X. While X may be warranted, no extenuating circumstances or objective functional performance has been documented to warrant X. X is not medically necessary and non certified.

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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)**