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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. X was in a good work history when X. The diagnosis was neck pain.

On X, X was seen by X, DO for follow-up. X was eagerly waiting to go ahead with a X. Unfortunately, a peer doctor was unfamiliar with this procedure. Evidently, X was

“ASA III status” X had X. X required X. As a result, they were recommending similar treatment. X had already represented fear and anxiety. X did not want a X or X but realized the benefits clearly outweigh the risks. X medications had stabilized including X. X was off X. Unfortunately, this denial of care necessitated coming back to their office, raising healthcare costs. At the time, X had decreased neck range of motion to the right. X was expressing anxiety, but however X wanted to proceed with this as soon as possible, arrange for pending insurance authorization. “X” was satisfactory. Online psych assessment showed X. Further delays would lead to refractory costly pain complaints. They spent extra time at the time, going over the peer review visit and why did the denial was placed and X felt it was “absurd.”

An MRI of the cervical spine dated X revealed X. These changes combined to X. The X was most prominent at X. X was noted. More prominent areas of X was noted.

Treatment to date included X on X with X improvement, and X.

Per a utilization review adverse determination letter dated X by X, MD, the prospective request for X was denied. Rationale: "Per ODG, 'X): Documentation of sustained improvement of pain or function of X, as measured from baseline, for X weeks after X; Pain or deterioration in function since X; Pain causes functional disability. Claimant has had X. Procedure performed X. X. X.'" In this case, it was documented that the claimant reported X improvement with the X. However, there was no evidence of improvement as the X. There was no evidence of improved functional measures, decreased medication use or reduced work restrictions. Additionally, X is not supported for the requested procedure. Consequently, a medical necessity is not established and the request for a X is non-certified."

Per a follow-up visit by Dr. X dated X, X was eagerly waiting to go ahead with X. Over one month back, X got excellent pain "relief," improved function, decreased left shoulder pain, improved range of motion, less headaches, and better sleep following X. "Unfortunately, the doctor who reviewed this case and they had to bring X back." "Unfortunately, raising healthcare cost, raising suffering, and also raising concern that a peer doctor did not do their due diligence." X was clearly X. X could just read X note and saw that doctor. X received this care, void of side effect. X did not develop any headaches or fluid retention. As a result of this denial of care, X felt that the neck pain was coming back requiring raising X X. X had neck stiffness and decreased neck range of motion. X also had decreased strength in X left shoulder with shoulder raise consistent with X. X MRI had been corroborated as X had a X. As a result, they were recommending X. Due to the denial, they had to spend extra time going over the peer review process with X over the notes as to why this was denied, apparently the doctor either did not look at their notes or call X and see that the criteria had been met. Due to X ASA III status, fear, and anxiety, X would require X for a X. In meantime, X X was satisfactory.

Per a reconsideration / utilization review adverse determination letter by X, MD dated X, the prospective request for X was denied. Rationale: "Regarding X, the Official Disability Guidelines state that X are recommended as a first-line or second-line option in case of radicular pain lasting X weeks, with a history of cervical radiculopathy, and diagnostic imaging correlates with symptoms, failure to respond to = X weeks of conservative care. A repeat X is recommended in a patient with good response to the initial injection, with documentation of sustained improvement of pain or function of = X, as measured from baseline, for = X weeks after X, and return of pain or deterioration in function since X. It is not recommended for when performed at levels above X. The use of X is not recommended due to the need for potential patient reports of symptoms during the procedure. The request is not supported. The prior utilization review from X non-certified the request based on no evidence of improvement including pain levels on a numerical rating scale (NRS), visual analog scales (VAS), or other acceptable methods, no evidence of improved functional measures, decreased medication use or reduced work restrictions. As such, per recent records, although it was noted that the claimant had X relief in pain with improved functions from the X, the submitted records for review do not document the previous and current significant objective exam findings for review. It is unclear if the claimant has had sustained improvement of pain or function that is measured from baseline after the prior procedure as suggested by the guidelines as the duration of benefits is not documented in recent records. Further, the imaging study is from X, as such there is no recent and formal documentation of any diagnostic study has been provided. To add on, the guidelines also do not support the use of X for this procedure. As such the request cannot be certified. Therefore, the request for X is non-certified."

It was noted that the claimant had X relief in pain with improved functions from the X. The submitted records for review do not document

the previous and current significant objective exam findings for review. It is unclear if the claimant has had sustained improvement of pain or function that is measured from baseline after the prior procedure as suggested by the guidelines as the duration of benefits is not documented in recent records. Further, the imaging study is from X, as such there is no recent and formal documentation of any diagnostic study has been provided. The guidelines also do not support the use of X for this procedure. No new information has been provided which would overturn the previous denials. Prospective request for 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:

It was noted that the claimant had X relief in pain with improved functions from the X. The submitted records for review do not document the previous and current significant objective exam findings for review. It is unclear if the claimant has had sustained improvement of pain or function that is measured from baseline after the prior procedure as suggested by the guidelines as the duration of benefits is not documented in recent records. Further, the imaging study is from X, as such there is no recent and formal documentation of any diagnostic study has been provided. The guidelines also do not support the use of X for this procedure. No new information has been provided which would overturn the previous denials. Prospective request for 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:

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- TMF SCREENING CRITERIA MANUAL
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- MILLIMAN CARE GUIDELINES
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- INTERQUAL CRITERIA
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE