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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 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. The biomechanics of the injury is not available in the records. The diagnosis was chronic pain, lumbar radiculopathy, cervical radiculopathy, thoracic radiculopathy, headaches, post-laminectomy syndrome, muscle spasm, and myalgia / myositis.

On X, X, PA evaluated X for a follow-up visit and medication refill. X had worsening pain in X cervical and lumbar spine. X complained of cervical, thoracic, and lumbar spine pain. X did report radiating pain going down the right arm and bilateral legs. The pain was described as aching, stabbing, throbbing, and tingling. The pain worsened when X was standing, walking, head rotation, sitting for long periods of time and other daily activities. X did have a history of X. X stated X continued that X had been having continued severe neck pain and having decreased range of motion. X admitted to stiffness and knots on X neck which had become worse and decreased X ability to perform X ADL's, X complained of pain into the right buttock since X. This pain did radiate into the right lower extremity with driving or prolonged walking. X also reported needles, pins, and numbness on the lateral aspect of X left leg which went down into X knee. X had tried and failed over-the-counter pain medication such as X. X had also tried prescription medications including X as directed, which provided X with some relief and was able to function better with X daily activities. X stated X would like to X. On examination, X was in moderate distress. X had limited X. Neck revealed pain with X. Musculoskeletal examination revealed X. Thoracic spine had reduced range of motion, tenderness to palpation, spasms (severe pain with motion, more so with rotation and flexing forward).

Per an imaging order dated X, X, MD ordered an X.

On X, X, MD evaluated X for complaints of chronic pain, lumbar radiculopathy, cervical radiculopathy, thoracic radiculopathy, headaches, post-laminectomy syndrome, muscle spasm, and myalgia / myositis. X had tried and failed the following: (X. An MRI of lumbar spine was reviewed revealing advanced X. At X. Based on the MRI and clinical finding, X was recommended to continue X ongoing medication and X Workers' Compensation benefits.

X-rays of the cervical spine dated X revealed X.

Treatment to date consisted of medications (X.

Per a peer review dated X and a utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: “The claimant was seen in X by another provider who noted X had neck and right arm pain. X had a prior X. That provider requested X. There is no mention of doing an MRI. That is the only note. There is no evidence of any X. There is no note by the X or updated clinical information to support doing this as well. Therefore, the request for the X is not medically necessary.”

Per a utilization review adverse determination letter dated X, the request for X was denied. Rationale: “After peer review of medical information presented and/or discussion with the Physician Advisor and the medical provider, it had been determined that the health care service(s) requested does not meet established standards of medical necessity.”

Per a peer review dated X, by X, MD, the appeal request for X was denied. Rationale: “The claimant had a X. MRI of cervical spine dated X reported X. There is lack of sufficient documentation of progressively worsening of symptoms or neurological signs justifying the medical necessity of the given request. Therefore, X is not medically necessary.”

An appeal letter dated X was included in the records about appeal request for X.

The requested X is not medically necessary. The submitted medical records do not indicate the X. No new information has been provided which would overturn the previous denials. 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:

The requested X is not medically necessary. The submitted medical records do not indicate the X X. No new information has been provided which would overturn the

previous denials 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