True Decisions Inc.

Notice of Independent Review Decision

True Decisions Inc.
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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

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X stated X was trying to put away the X. When X tried to put it away, the X. The diagnosis was sprain of joints and ligaments of unspecified parts of neck.

On X, X was seen by X, PT, for physical therapy initial evaluation for X ongoing complaints. X complained of right wrist and neck pain. X rated the pain X. X was referred to X sustained last X. X stated that X was trying to X. The pain was aggravated on sitting in front of computer for extended periods and alleviated with hot baths, stop pain roll, braces and pain medication. X reported that X was being unable to participate fully in one or more community or life events due to impairments associated with ongoing injury. Cervical spine examination revealed that X. Suboccipitals showed X. The active range of motion was noted with tightness and pain, at flexion was X degrees, extension X degrees, right side bending X degrees, left side bending was X degrees, right rotation was X degrees and left rotation was X degrees. The muscle strength at flexion was X, extension X, right side bending X, left side bending was X, right rotation was X and left rotation was X. Normal gait with no observed deviations was noted. There was moderate X noted. On assessment, X was advised for frequency of X. This included X. On X, X by evaluated by X, FNP, presented for follow-up visit. X presented for recheck for X, due to work-related injury dated X. X stated X was trying to X. X had completed X, however, had not reached X of X goals. X benefited from X as per recommendations of X. The 2nd order of X would be placed and a X. X would continue with restrictions. On examination, blood pressure was 120/78 mmHg, weight 161 pounds and body mass index (BMI) was 29.45 kg/m2. Physical examination revealed X

was well appearing and well nourished. The neck was X. Pulmonary examination revealed X. Extremities were X. X was X. Cervical spine showed X. The reflexes were X. The right wrist was X. The right wrist was noted with brace, appeared with swelling. There was tenderness in the ulnar aspect and the radial aspect. There was tenderness with movement, with pain. there was pain with flexion, extension, radial and ulnar deviation. Tenderness was present in the right trapezius muscle and left trapezius muscle. Palpation revealed bilateral muscle spasms. Full range of motion was noted. Flexion and extension were painful. It was noted X was approximately X of the way toward meeting the physical requirements of X job. The assessment was sprain of neck, right wrist sprain, head contusion, left wrist sprain, and contusion of left little finger. X was started. X was recommended for X. X was allowed to return to work with restrictions and may work the entire shift. The restrictions included pushing / pulling, grasping / squeezing, and wrist flexion / extension for a maximum of X hours; no (0 hours) climbing stairs / ladders or overhead reaching, and no lifting / carrying objects more than X pounds.

An x-ray of the cervical spine dated X revealed X. there was X noted. X.

Treatment to date included X.

Per a utilization review adverse determination letter / Peer Review Report dated X by X, DO, the request X was denied. Rationale: “ODG by MCG Last review/update date: X: Physical Medicine "X. X: X. X". The patient has previously undergone X. There are X. Therefore, the request for X is non-certified.”

On X, X, wrote an appeal letter regarding X request for X, stating, “This is a preauthorization request for reconsideration (appeal) for X. The medical

provider, X, NP, has requested this medical treatment because there is an ongoing condition(s) that requires treatment. The X), The attached medical records support the X; and establish the clinical indication and necessity of this treatment. Therefore, the X should be determined medically necessary for claimant to reach MMI."

Per a reconsideration review adverse determination letter / peer review report dated X by X, MD, the appeal request for X was denied. The prior denial was upheld by the physician advisor. Rationale: "X. X "Sprains and strains of neck: X." Per the reviewed records, this claimant has X. Each X note stated that the patient had only achieved X of the treatment goal for the neck, although the documented cervical spine active range of motion and muscle strength testing was unchanged at each visit and identical to that documented at the initial session on X. At the therapy visit on X, X reported feeling a little better. At the most recent office visit on X, the patient had now completed X. The cervical spine exam was X. The recommendation was for X. A recent request X. I am in agreement with the prior determination. ODG recommends up to X. In this case, the patient X. Additionally, at the last documented office visit X ago on X, the patient now had full range of motion with complaints of pain with extension and flexion. No recent exam is documented showing current deficits to support this request for X. Given lack of X. No extenuating circumstances are noted to support overriding the prior determination. Thus, this appeal request is not certified. Therefore, the request for X is not certified."

Thoroughly reviewed provided records including provider notes and peer reviews.

Patient recovering X. Given progressing with therapy with both subjective pain decrease as well as objectively with improvement with range of

motion on some documentation, further X appears warranted. 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 and peer reviews.

Patient recovering X. Given progressing with therapy with both subjective pain decrease as well as objectively with improvement with range of motion on some documentation, further X appears warranted. X is medically necessary and certified

Overturned

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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