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Notice of Independent Review Decision

IRO Reviewer Report

X

IRO Case #: X

Description of the service 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/approved.

Information Provided to IRO for Review:

X

Patient Clinical History [Summary]:

All of the listed records were reviewed.

The member is a X who sustained an injury on X. The member stated that X.

The member was diagnosed with concussion with loss of consciousness of 30 minutes or less, sprain of ligaments of the cervical spine, strain of muscle, fascia, and tendon at the neck level, radiculopathy of the cervical region, sprain of ligaments of the thoracic spine, and a strain of muscle and tendon of the back wall of the thorax.

Magnetic resonance imaging of the cervical spine without contrast dated X showed a X. At the X, X. At the X. Abnormal straightening of the normal cervical spine curvature, suggesting muscle spasm.

Magnetic resonance imaging of the thoracic spine, dated X, showed X.

A magnetic resonance imaging of the left shoulder without contrast was performed on X and revealed a X. A small amount of X.

Magnetic resonance imaging of the cervical spine without contrast dated X showed X. The X was straightened. X resulted in the X.

Magnetic resonance imaging of the brain with diffusion tensor imaging without contrast dated X showed X. Diffusion tensor imaging was X.

Magnetic resonance imaging of the brain without contrast dated X showed X. Otherwise, an unremarkable magnetic resonance imaging of the brain without contrast.

According to a mental health evaluation dated X, the member reported a high level of pain in the head and neck. The member had X. The mental status evaluation revealed X. There was an apprehensive effect, and the voice and demeanor reflected a high level of frustration and depression. The score was X on the Beck depression inventory, which placed the member in moderate depression. The Beck anxiety score was X, placing the member in a severe anxiety level. On the fear-avoidance belief questionnaire, the member scored a low score of X on the physical activity portion of the assessment and a high score of X on the work portion. On the Oswestry neck pain disability questionnaire, the member scored X, indicating severe/crippled disability, neck pain impinges on all aspects of the member's life, and positive intervention was required. Per the impairment rating scale, the pain was rated at X at worst, best, and on average. The member reported being X on the importance and confidence scale, being somewhat important for the reduction and management of pain, X for being somewhat important to return to work, X for being somewhat confident in the motivation to reduce and manage pain more effectively, and X on some confidence on the ability to return to work currently. Per the conclusion of the provider, the member's motivation was high, but they had difficulty adjusting to the present health

situation. The intervention was recommended due to the high scores and symptoms.

According to a session of individual therapy dated X, the member was very quiet and asked pertinent questions during the session. The injury and pain affected the member's daily living. The member stated having constant headaches but tried to push through. The member liked to attend church and found it helped as a distraction from the pain and stress of not working. The examination revealed that the member had difficulty identifying and expressing feelings and was passive and quiet. The member waited for the provider to initiate a discussion. The assessment revealed that short-term goal-setting and coping strategies were discussed. The plan included continuing plan without change.

The member had X. According to the X note dated X, the member had a total of X. The member noted intermittent headaches, which had resolved with X. The intensity of the pain would be rated at X. Looking down and bending over increased the overall pain level. The member noted seeing stars when looking down or bending over. The member also reported some difficulty focusing/concentrating, memory, and depression, which were improving. The medication would decrease overall pain. There were also complaints of intermittent pain in the neck that extended into the upper trapezius, as well as a feeling of fatigue. The intensity of the pain was reported at X, with turning and looking down and activities associated with normal daily activities increasing the overall pain level. The member noted that lying down, massaging, applying heat, and X would help decrease the pain overall. The physical exam noted continued guarding of the head/neck, very X. There were decreased deep

tendon reflexes at X. A motor strength grade of X involved cervical bilateral flexion and thoracic bilateral rotation. There were X. There was a X. The diagnoses were a concussion with loss of consciousness of 30 minutes or less, sprain of ligaments of the cervical spine, strain of muscle, fascia, and tendon at the neck level, radiculopathy of the cervical region, sprain of ligaments of the thoracic spine, and a strain of muscle and tendon of the back wall of the thorax. The plan included an appeal for the X.

According to a report of functional capacity evaluation dated X, the member's occupation's job demand was at a medium physical demand level, but due to the performance, it was sedentary to sedentary light. The member was experiencing a severe functional deficit as it related to meeting the standing, walking, bending, reaching overhead, reaching out, squatting, floor lifting, floor to-shoulder lifting, floor overhead lifting, two hands carrying, pushing, and pulling job criteria as defined by the dictionary of occupational titles and/or the member's job description interview. The recommendations revealed that the member's injury had reached a plateau in care, and no further treatments were planned. The member had not returned to work; however, the position was still available, and the employer did not offer light duty/modified duty. Based on the results of the exam and considering the X mental health evaluation, an X.

According to a mental health evaluation dated X, the member had been referred to further assess the difficulty with pain and overall adjustment issues related to the injury. The member reported a high level of pain in the head, neck, and back. The member exhibited symptoms of stress, anxiety, and depression,

with a constricted affect and a depressed and anxious voice and demeanor accompanied by a slow and low tone. Per the member Health Questionnaire, the member scored in the moderate range (X), indicating moderate depressive symptoms, making it extremely difficult to work, care for things at home, and get along with others. Per the Generalized Anxiety Disorder-7 questionnaire, the member scored in the moderate range (X), indicating that the member experienced moderate levels of anxiety symptoms that made it difficult to work, take care of things, and get along with others. The member was experiencing severe symptoms with significant mental distress related to the injury and pain experience. Treatment was recommended to decrease or manage the moderate symptoms experienced by the member, as the symptoms adversely affected daily life and the ability to return to work. Per the fear-avoidance belief questionnaire, the member scored a median score of X on the physical activity portion of the assessment and a high score of X on the work portion of the assessment. Per the Oswestry Lower Back Pain Disability Questionnaire, the member scored X, indicating that the member was crippled and that back pain impinged on all aspects of life. Positive intervention was required. Per the Oswestry Neck Pain Disability Questionnaire, the member scored X, which indicated crippled disability and back pain, which impinged on all aspects of the member's life. Per the impairment rating scale, the member rated the pain at X at worst, X at least, and X on average. Per the provider, the member was recommended for the X. The member had high motivation but had difficulty adjusting to the present health situation. The member was strongly recommended to attend X.

Per the Utilization Peer Reviewer's Response dated X, the

requested X was non-certified.

On X, the request for an X was non-certified by the peer-review doctor.

According to a determination reported dated X, the reviewer denied the recommendation for X.

On X, a request for an overturn of the carrier's adverse determination for X.

Analysis and Explanation of the Decision include basis, findings, and conclusions used to support the decision:

In this case, the member sustained an injury on X. The member sustained an injury in which a X. The member was diagnosed with concussion with loss of consciousness of 30 minutes or less, sprain of ligaments of the cervical spine, strain of muscle, fascia, and tendon at the neck level, radiculopathy of the cervical region, sprain of ligaments of the thoracic spine, and a strain of muscle and tendon of the back wall of the thorax. Magnetic resonance imaging (MRI) of the cervical spine dated X showed a X. At the X. At the X. Abnormal straightening of the normal X. Magnetic resonance imaging of the thoracic spine dated X showed a X dated X revealed a X. A small amount of X. Magnetic resonance imaging of the cervical spine dated X showed X. Magnetic resonance imaging of the brain with diffusion tensor imaging without contrast dated X showed X. Magnetic resonance imaging of the brain without contrast dated X showed X. According to a mental health evaluation dated X,

the member reported a high level of pain in the head and neck. The member has high motivation but difficulty adjusting to the present health situation. The mental status evaluation revealed symptoms of stress and anxiety. The member had X. According to the X note X, the member complained of intermittent pain in the neck that extended into the upper trapezius, as well as a feeling of fatigue. The pain intensity was reported at X, with turning and looking down and activities associated with normal daily activities increasing the overall pain level. The physical exam noted X. There were decreased X. A motor strength grade X involved X. There were bilaterally X. There was a decreased range of motion on X. The member attended a functional capacity evaluation dated X; the member was experiencing a severe functional deficit as it related to meeting the standing, walking, bending, reaching overhead, reaching out, squatting, floor lifting, floor to-shoulder lifting, floor overhead lifting, two hands carrying, pushing, and pulling. According to a mental health evaluation dated X, the member had been referred to further assess the difficulty with pain and overall adjustment issues related to the injury. The member reported a high level of pain in the head, neck, and back. The member exhibited symptoms of stress, anxiety, and depression, with a constricted affect and a depressed and anxious voice and demeanor accompanied by a slow and low tone. Per the member Health Questionnaire, the member scored in the moderate range (24), indicating moderate depressive symptoms, making it extremely difficult to work, care for things at home, and get along with others. Per the Generalized Anxiety Disorder-7 questionnaire, the member scored in the moderate range (X), indicating that the member experienced moderate levels of anxiety symptoms that made it difficult to work, take care of things, and get along with

others. The member was experiencing severe symptoms with significant mental distress related to the injury and pain experience. Per the Oswestry Neck Pain Disability Questionnaire, the member scored X, which indicated crippled disability and back pain, which impinged on all aspects of the member's life. Per the impairment rating scale, the member rated the pain at X at worst, X at least, and X on average. Based on the medical records provided, the member underwent a consistent course of treatment, resulting in a request for X. The request was denied by peer review with the rationale that there was no documentation that the member had completed X. The provider submitted the physical therapy notes indicating that the member received X. On appeal, the request was denied. The rationale for the denial was that the member did not have a job to return to. The provider submitted an appeal in which the provider stated that the member has a specific job as an X. The member's work as an X is at a medium physical demand level. The member is functioning below the medium's job-required physical demand level. Simply because the member was X. The provider's appeal letters appropriately addressed and rebutted the rationale for the denial of the X. X is appropriate for members who have X. The member underwent a functional capacity evaluation, revealing that the member was functioning below the job-required physical demand level for an X. There was evidence of psychosocial overlay. Given the functional deficits and psychosocial overlay and failure of conservative treatment, the requested X is medically necessary.

A description, and the source of the screening criteria or other clinical basis used to make the decision:

X

ODG by MCG
Last review/update date: X