

C-IRO Inc.

Notice of Independent Review Decision

C-IRO Inc.

An Independent Review Organization

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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:

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- Overturned (Disagree)
- Partially Overturned (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 who was injured on X, while working as an X. On this day, there was a winter storm with ice on the pavement and X related that X slid and fell probably on concrete. Following the first fall, X again upon standing, fell twice. The diagnosis was 1) Post concussion head syndrome with persistent full body pain including daily headaches, worsening of history of migraine, and neuropathic pain syndrome. 2) Complex regional pain syndrome of the upper and lower extremities following traumatic head injury could not be ruled out. 3) Secondary myofascial pain syndrome with dystonia of the neck, shoulder, upper back with spread to lower extremities with motor coordination deficits having been ruled out for central motor neuron disease.

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X was seen by X, DO, on X for an initial pain evaluation. X presented with a chief complaint of chronic persistent severe body pain beginning in the head, neck associated with daily headaches, numbness, coordination difficulties, sensitivity to touch, and mood irritability. X gave a longstanding history of migraines, depression, when X injured X head and neck with a sudden fall while at work on X. On that date, X suffered a concussion head syndrome, sprain of the cervical ligaments, and subsequently, X had undergone X. Due to the persistent nature of X pain, X was being seen by a psychiatrist with a sundry of medications. X had an unremarkable head CT scan with no evidence of hemorrhage, mass, or infarct. X had undergone numerous evaluations including vestibular ocular testing, which showed abnormalities with evidence of central and peripheral vestibular dysfunction. X had difficulty sleeping. X had progressive pain in X neck and upper back area. X presented with X supportive mom. X walked with now an antalgic gait utilizing cane support device for coordination and felt this pain was worsening. X admitted to involuntary spasms in the neck and upper back area. X admitted to proprioception deficits and worsening mood. X did not sleep throughout the course of the night. X CESD was X consistent with moderate-to-severe reactive depression. X ORT or risk for opioid misuse was moderate risk, X GAD-7 was X. X spot urinalysis was X. X pain was anywhere from X. Vitamin D supplementation was encouraged. X admitted to weight loss and headaches on almost a daily basis without aura. Examination noted a constricted affect and depressed mood. X

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walked with a slow, deliberate gait utilizing cane support device. Trigger point tenderness was noted with hyperesthesia and allodynia throughout the neck, shoulder, and upper back areas. X had decreased grip strength, left and right, with hyperesthesia and allodynia to passive range of motion and light touch. The assessment was: 1) Post concussion head syndrome with persistent full body pain including daily headaches, worsening of history of migraine, and neuropathic pain syndrome. 2) Complex regional pain syndrome of the upper and lower extremities following traumatic head injury could not be ruled out. 3) Secondary myofascial pain syndrome with dystonia of the neck, shoulder, upper back with spread to lower extremities with motor coordination deficits having been ruled out for central motor neuron disease. Dr. X noted that X The patient's prognosis was fair, and discussed the multidisciplinary nature of neuropathic pain, C-unmyelinated fiber dysfunction associated autonomic dysfunction following head injury. This would take time. X would continue with X psychiatrist and neurologic follow-up, In the meantime, Dr. X believed for neuropathic pain and went over a class of medicines, X had not tried in the neuromodulator class, which helped in this condition, Formally, anticonvulsants since beginning at X; X would work that up; X worse pain was in the mid-morning and afternoon hours. Dr. X would like X to take these prior to initiation of pain. Daily walking, vitamin D supplementation, exercise therapy for active range of motion throughout the body was encouraged. Once adequate medical management had been established, X in the

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upper and lower extremities may go a long way in helping reduce X headache symptoms, improve X function and overall activities of daily living. X was highly efficacious in this disorder. They would certainly try a more conservative approach initially. An anti-inflammatory diet was advised. Elimination of simple sugars, carbohydrates, and keeping caffeinated beverages at bay was recommended, and a follow-up appointment was made in X weeks' time. Per the X follow-up note, X had already been noticing some improvement following institution of Dr. X care including medical management utilizing X that X was now going to raise to X. They discussed definitive treatment for X ongoing pain complaints associated with post concussion head syndrome, cervical dysfunction including cervicogenic headache, post concussion head syndrome complicated with signs and symptoms consistent with CRPS of neuropathic pain in origin. Dr. X recommended a X. This would provide X. X would be reserved for recalcitrant pain. On X, X continued with marked left arm and hand pain. Dr. X would arrange for X, pending insurance authorization, and noted, "Further delays in this treatment will lead to refractory costly pain complaint with propensity to spread proximally to include further neck pain, headaches, arm sensitivity to touch and temperature changes. X has decreased pinprick sensation in a nonsegmental dermatomal fashion as well as hyperesthesia and allodynia consistent with complex regional pain syndrome or neuropathic pain of X left arm and hand. Due to dual pain generators, both the cervical disc disruptions as well as the primary autonomic dysfunction associated with

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neuropathic pain. Unfortunately, the peer doctor did not do their due diligence. They did not refer to our history and physical. They did not cite the X. As a result of this denial, the patient and X mom had to drive over X hours to see us, for this denial, we had to spend extra time going over the denial of process. Furthermore, we had to upgrade X medicine X is advised.”

An MRI of the cervical spine dated X, demonstrated X.

Treatment to date included medications (X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD, as not medically necessary. Rationale: “Regarding X, ODG states that X may be indicated when radicular pain of duration of greater than or equal to X weeks and cervical radiculopathy by history (radiation of pain and numbness along the distribution of the affected spinal root), and diagnostic imaging correlates with symptoms, X is performed at X. In this case, the documentation is absent evidence of pain radiating from neck into the upper extremities in a dermatomal pattern. There are no sensory, motor or reflex deficits at any cervical level on the physical exam. The clinical presentation is consistent with neuropathic pain and not radicular pain. Given that the evidence-based guideline criteria have not been met, the medical necessity of this request is not established. Recommendation is to deny the request.”

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Per a reconsideration review adverse determination letter dated X, the request for X was denied by Paul Loubser, MD. Rationale: "The request for appeal X is not recommended as medically necessary. The claimant was injured when X. X injured X head and neck. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no significant neurocompressive pathology on MRI of the cervical spine. The submitted exam findings fail to document radicular findings. Therefore, medical necessity is not established in accordance with current evidence-based guidelines." The clinical basis for the determination was as follows: "The claimant is a X whose date of injury is X. The claimant was injured when X slipped and X. X injured X head and neck. CT of the head was noted to be unremarkable. MRI of the brain is a normal study. MRI cervical spine dated X. Follow up note dated X indicates that the claimant is noticing some improvement now that X is taking X. It is noted that post concussion head syndrome complicated with signs and symptoms are consistent with CRPS of neuropathic pain in origin. Claimant is recommended for X. Note dated X indicates that the claimant continues with marked left arm, hand pain. X has decreased X. The initial request was non-certified noting that, "In this case, the documentation is absent evidence of pain radiating from neck into the upper extremities in a dermatomal pattern. There are no sensory, motor or reflex deficits at any cervical level on the physical exam. The clinical presentation is consistent with neuropathic pain and not radicular pain.

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Thoroughly reviewed provided records including peer reviews.

Patient with signs and symptoms of X as documented by provider. While X may be considered at this juncture, the provider's specific request and documentation may be misinterpreted as attempting to obtain an X. However, patient is being treated for X is being requested. Based on cited ODG Criteria, as well as standard of care, requested procedure is 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 peer reviews.

Patient with signs and symptoms of X as documented by provider. While X may be considered at this juncture, the provider's specific request and documentation may be misinterpreted as attempting to obtain an X. However, patient is being treated for X is being requested. Based on cited ODG Criteria, as well as standard of care, requested procedure is warranted. X is medically necessary and certified

Overtured

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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**

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PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)