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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 Overtuned (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. X stated X was in X usual health until X when X was X. The diagnosis was strain of muscle, fascia, and tendon at neck level, subsequent encounter (X).

On X, X was evaluated by X, MD for the chief complaint of thoracic back pain, bilateral neck pain, headache, and low back pain. The pain was described as aching, sharp, stabbing, and deep. X reported X was able to live at home and care for most personal needs, with varying amount of assistance needed. Examination noted X was in mild distress. Cervical spine inspection revealed X. Neurologically, there was X. Motor revealed X. The assessment was strain of neck muscle. Dr. X noted that X presented with continued complaints of neck pain that radiated into X bilateral shoulders and down X arms (left greater than right). Previously, a X was recommended; however, this procedure had been denied by X carrier. Review of the denial stated that X cervical spine MRI did not correlate with a X. Review of X cervical spine MRI revealed a X. There was also a X. On physical exam, X had a X. X had interosseous and grip strength weakness in the left hand. Therefore, X cervical spine MRI did correlate with X symptoms and physical exam findings. Dr. X further wrote, “For this reason, I continue to believe it is medically appropriate for the patient to proceed with a X.” Further treatment recommendations will be made depending on the results of the procedure. X reported minimal benefit from the X. X would be rotated to X as needed. X was discontinued and X started.

An MRI of the cervical spine without contrast, dated X, demonstrated at X. At X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “ODG guidelines state that X. The pain radiated in the bilateral arms. The quality of the pain was sharp and throbbing. X stated pain was tolerable with ongoing medication, X had a status post X. X stated X obtained a X benefit from the procedure. On examination of the X. There was a X. An MRI of the cervical spine dated X revealed at X. Although the claimant has significant clinical findings, documentation does not indicate failed physical therapy, thus not supported by guidelines. As such, the request for X, is not medically necessary.”

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “Per ODG, "X may be indicated when ALL of the following are present X, is non-certified."

Thoroughly reviewed provided records including provider notes, imaging results, and peer reviews.

The patient has continued pain in potentially radicular distribution despite conservative treatment. This pain appears to correlate with MRI findings of X. Thus, request for 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, imaging results, and peer reviews.

The patient has continued pain in potentially radicular distribution despite conservative treatment. This pain appears to correlate with MRI findings of X. Thus, request for X is medically necessary and certified

Overturned

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**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**