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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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:
X who was injured on X. The mechanism of injury included that X was X. X reported hitting head on the ground and loss of consciousness. The diagnoses were spondylosis without myelopathy or radiculopathy, cervical region (X), cervicalgia (X) and cramp and spasm (X).

On X, X was seen by X, NP for follow-up evaluation of chief complaint of chronic neck pain. X reported that X was still rated X neck pain at X. X continued to have difficulty with motion. X was using a X. X were ordered for the cervical region, but still had not been approved. An updated X was also ordered; it had been approved as well. X continued to show tension across the upper thoracic and lower cervical paraspinals. X would X. Previously X rated the pain at X but on the day, X rated it as X, showing improvement. X was started. X was doing X. The only resistance was related to X. X was not X. On examination, X was obese. X did show tremor activity just with standing Psychiatric examination showed X. Cervical spine examination revealed X. Flexion was X. Compression test was X at X. Moderate X across the X was noted. X on the left side were noted. Neurological examination for the upper extremity showed increased pain into the upper extremities on the left. Muscle testing was X. Reflexes were X. Gait was X. On assessment, the X was once again ordered.

A CT scan of the cervical spine on X revealed X. There was X noted. There were X. There was X was noted. There were X. At X, there was mild right greater than left X. At X, there was posterior central disc protrusion X mm without X. There was mild left greater than right X. At X, there was disc bulge with a true disc bulge up to X mm resulting in X estimated near X mm potentially with contouring of the ventral spinal cord. There was mild right and X. At X, there was X complex relation to X mm X mm likely with contouring of the ventral spinal cord; X. At X, there was posterior X relation to X mm stenosis estimated X mm and potential for contact on the ventral spinal cord asymmetric toward the left; mild left X. At X, there was X.

Treatment to date included X.

Per a utilization review adverse determination letter / peer review report dated X,

the request for X was denied by X, MD. Rationale: “Per ODG by MCG, X (Last review/update date: X), "Imaging studies and physical examination have ruled out other causes of spinal pain (e.g., fracture, herniated disc, spinal stenosis, tumor)." The patient is being seen for neck pain. Upon examination of the neck, there is limited ROM (normal flexion), positive compression test for facet and axial loading pain at X, moderate hypertonicity across the cervical and upper thoracic paraspinals bilaterally, trigger points on the left side, increased pain into the left upper extremity, decreased strength in bilateral upper extremities, hyporeflexive, and an antalgic gait. Strength is X. CT of the cervical spine on X showed X more pronounced at X and to a lesser degree at X, moderate X at left X, and X. A peer to peer discussion was done on X at X AM CT and I spoke to X, Workers Compensation Liaison. X reports no knowledge at this time regarding the outcome of the planned X for the patient as per treatment note dated X. X reports there has been no discussions regarding plans for X. Per guidelines, X is indicated when imaging has ruled out other causes of pain. In this case, CT imaging reveals X. In addition, X was planned with no report regarding outcome of this X. Therefore, the request for X is not certified.”

Per a reconsideration review adverse determination letter / peer review report dated X, the request for X was denied by X, MD. Rationale: “The claimant was evaluated with chronic neck pain and has undergone X. Objectively, examination reveals persistent neck pain rated at X, limited range of motion in extension, right and left rotation, and right and left lateral flexion of the cervical spine, positive X, moderate hypertonicity across the cervical and upper thoracic paraspinals, trigger points on the left side, increased pain into the left upper extremity, decreased strength in bilateral upper extremities, hyporeflexive reflexes, and an antalgic gait, despite X motor strength in all tested areas. However, the critical ODG by MCG criterion, imaging studies and physical examination have ruled out other causes of spinal pain (e.g., fracture, herniated disc, spinal stenosis, tumor), has not been met. A CT of the cervical spine dated X, explicitly documented X. These findings indicate that other causes of spinal pain, specifically X, have been identified rather than ruled out by imaging. Furthermore, a peer-to-peer discussion on X, indicated no knowledge regarding the outcome of the recently planned X. Therefore, based on the medical necessity criteria that require imaging to rule out other pain causes, and the lack of a reported outcome from X is not supported. As such, the request is recommended upheld.”

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter / peer review report dated X, the request for X was denied by X, MD. Rationale: “Per ODG by MCG, X (Last review/update date: X, "Imaging studies and physical examination have ruled out other causes of spinal pain (e.g., fracture, herniated disc, spinal stenosis, tumor)." The patient is being seen for neck pain. Upon examination of the neck, there is limited ROM (normal flexion), positive compression test for X and X, moderate hypertonicity across the cervical and upper thoracic paraspinals bilaterally, trigger points on the left side, increased pain into the left upper extremity, decreased strength in bilateral upper extremities, hyporeflexive, and an antalgic gait. Strength is X. CT of the cervical spine on X showed X more pronounced at X and to a lesser degree at X, moderate X. A peer to peer discussion was done on X at X and I spoke to X, Workers Compensation Liaison. X reports no knowledge at this time regarding the outcome of the planned X for the patient as per treatment note dated X. X reports there has been no discussions regarding plans for X. Per guidelines, X is indicated when imaging has ruled out other causes of pain. In this case, CT imaging reveals X. In addition, X was planned with no report regarding outcome of this conservative approach before implementing invasive treatment. Therefore, the request for X is not certified.” Per a reconsideration review adverse determination letter / peer review report dated X, the request for X was denied by X, MD. Rationale: “The claimant was evaluated with chronic neck pain and has X. Objectively, examination reveals persistent neck pain rated at X, limited range of motion in extension, right and left rotation, and right and left lateral flexion of the cervical spine, X, moderate hypertonicity across the cervical and upper thoracic paraspinals, trigger points on the left side, increased pain into the left upper extremity, decreased strength in bilateral upper extremities, hyporeflexive reflexes, and an antalgic gait, despite X motor strength in all tested areas. However, the critical ODG by MCG criterion, imaging studies and physical examination have ruled out other causes of spinal pain (e.g., fracture, herniated disc, spinal stenosis, tumor), has not been met. A CT of the cervical spine dated X, explicitly documented X. These findings indicate that other causes of spinal pain, specifically X, have been identified rather than ruled out by imaging. Furthermore, a peer-to-peer discussion on X, indicated no knowledge regarding the outcome of the recently planned X, suggesting that the full extent of conservative management has not been adequately assessed or

completed. Therefore, based on the medical necessity criteria that require imaging to rule out other pain causes, and the lack of a reported outcome from recent X, the requested X is not supported. As such, the request is recommended upheld. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. Guidelines require documentation of failure of at least X months of X and that imaging studies and physical examination have ruled out other causes of spinal pain (e.g., fracture, herniated disc, spinal stenosis, tumor). Recent imaging was reportedly authorized, but no official report was submitted for review. Prior cervical CT scan did note X. The patient's response to recent X is not adequately documented. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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:

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter / peer review report dated X, the request for X was denied by X, MD. Rationale: "Per ODG by MCG, X(Last review/update date: X), "Imaging studies and physical examination have ruled out other causes of spinal pain (e.g., fracture, herniated disc, spinal stenosis, tumor)." The patient is being seen for neck pain. Upon examination of the neck, there is X, moderate hypertonicity across the cervical and upper thoracic paraspinals bilaterally, trigger points on the left side, increased pain into the left upper extremity, decreased strength in bilateral upper extremities, hyporeflexive, and an antalgic gait. Strength is X. CT of the cervical spine on X showed X, and X. A peer to peer discussion was done on X and I spoke to X, Workers Compensation Liaison. X reports no knowledge at this time regarding the outcome of the X for the patient as per treatment note dated X. X reports there has been no discussions regarding plans for X. Per guidelines, X is indicated when imaging has ruled out other causes of pain. In this case, CT imaging reveals X. In addition, X was planned with no report regarding outcome of this conservative approach before implementing invasive treatment. Therefore, the request for X is not certified." Per a reconsideration review adverse determination letter / peer review report dated X, the request for X was denied by X, MD. Rationale: "The claimant was evaluated

with chronic neck pain and has X. Objectively, examination reveals persistent neck pain rated at X, limited range of motion in extension, right and left rotation, and right and left lateral flexion of the cervical spine, positive compression tests for X, moderate hypertonicity across the cervical and upper thoracic paraspinals, trigger points on the left side, increased pain into the left upper extremity, decreased strength in bilateral upper extremities, hyporeflexive reflexes, and an antalgic gait, despite X motor strength in all tested areas. However, the critical ODG by MCG criterion, imaging studies and physical examination have ruled out other causes of spinal pain (e.g., fracture, herniated disc, spinal stenosis, tumor), has not been met. A CT of the cervical spine dated X, explicitly documented X. These findings indicate that other causes of spinal pain, X, have been identified rather than ruled out by imaging. Furthermore, a peer-to-peer discussion on X, indicated no knowledge regarding the outcome of the recently X, suggesting that the full extent of conservative management has not been adequately assessed or completed. Therefore, based on the medical necessity criteria that require imaging to rule out other pain causes, and the lack of a reported outcome from X is not supported. As such, the request is recommended upheld. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. Guidelines require documentation of failure of at least X months of conservative treatment and that imaging studies and physical examination have ruled out other causes of spinal pain (e.g., fracture, herniated disc, spinal stenosis, tumor). Recent imaging was reportedly authorized, but no official report was submitted for review. Prior cervical CT scan did note X. The patient’s response to recent X is not adequately documented. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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