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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 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. The mechanism of injury was described as X. X was in the X. There was X. The diagnosis was acute nonintractable headache, unspecified headache type (X); concussion without loss of consciousness, initial encounter (X); strain of neck muscle, initial encounter (X); trapezius strain, left, initial encounter (X). On X, X followed up with X, PT for a X visit for the diagnosis of concussion without loss of consciousness, initial encounter (X). This was X. X reported having intense headache of the right-sided neck, radiating into the right orbital region, X in intensity. X could perform activities of daily living independently but could not perform recreational activities independently. X reported X had been performing X program. X had been given work restrictions by X treating medical provider, which limited X participation in one or more essential job functions. X reported being unable to participate fully in one or more community or life events due to impairments associated with ongoing injury. It was noted X had reached X of X functional goal at that visit. Continued assessment was required for anticipated visits required for discharge. Cervical left rotation active range of motion (AROM) was X degrees, with goal X achieved. The assessment was X. It was assessed that X overall progress was as expected. X reported having reduced X intensity in headache post manual treatment. In addition, pain was no longer present behind the right eye, centralized to the right-sided neck. It was recommended that X continue X per the treatment plan. X was performed to the cervical and thoracic spine to include X. Per an undated X visit note signed on X, by X, PT, X had X. X was seen for the diagnoses of trapezius strain, left, initial encounter (X); strain of right trapezius muscle, initial encounter (X); and strain of neck muscle, initial encounter (X). X reported X was X of the way to a full recovery and reported X headaches were still the most limiting factor. X continued to take pain medication to manage X headaches. X could perform activities of daily living independently but could not perform recreational activities independently. X reported being unable to participate fully in one or more community or life events due to impairments associated with the ongoing injury. X had been given restrictions by X medical provider which limited X participation in one or more essential job functions. It was assessed that X had shown significant progress on all fronts with regard to X. X continued to struggle with end-range pain with cervical movements (especially cervical flexion and extension). X continued to be heavily reliant on X of X headaches. X headaches had remained to present as if they were

musculoskeletal in nature, and they had responded well to X. Additional X was needed to address impairments in X and pain in order to tolerate functional requirements for full work duties. Additional X was recommended X. X had reached X of X functional goal at that visit, with cervical left rotation ongoing value of X degrees, with goal X achieved. Lift, carry, push / pull goals were X achieved. On X, X was evaluated by X, MD for follow-up on headache, left knee, and left ankle. X had been working modified duty. X reported X was in X. There was X. X reported the left leg was flexed when X landed, which caused abrasion to the left knee and ankle. X also had abrasion to X right ring finger. X stated X had seen a neurologist who advised X concussion symptoms should resolve on their own and X felt the headaches' origin could be a cervical spine and advised an X. A discussion with X that day revealed X had not had cervical / neck therapy. Dr. X would order X. X asked about work restrictions and Dr. X stated the expected time to return to work would be by the end of the month. Examination findings were within normal limits. It was noted X was X of the way toward meeting the physical requirements of X job. The assessment was X. A X was provided, X. It was noted X was medically necessary to address clinical impairment / functional loss and to expedite return to full activity. The ongoing restrictions were continued, to include no lifting / carrying, sedentary work only, and may not X as this was not sedentary work. A CT scan of the cervical spine dated X, demonstrated X. Straightening cervical alignment may be secondary to positioning or spasm. There was some 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: "The request is not medically necessary. In this case, the claimant has pain, extension at X degrees, side bend at X degrees on the right and X degrees on the left, right rotation at X degrees and left rotation at X degrees, X. The claimant has had X for the cervical spine. Guidelines recommend X for a cervical sprain. The quantity exceeds guidelines. Therefore, the X is not medically necessary." In a letter dated X, by X, LLC, X wrote, "This is a request for X. The medical provider, Dr. X has requested this medical treatment because there is an ongoing condition(s) that requires treatment, the recommended treatment relieves the effects of a compensable injury; and the recommended treatment promotes recovery. The goal of this reasonable and medically necessary treatment, which is consistent with the ODG, is to provide pain relief, increase performance in the activities of daily living, reduce claimant's symptoms, and reduce medication use. The medical records establish the clinical indication and necessity of this

procedure.” Per a reconsideration review adverse determination letter dated X, the appeal request for X, was denied by X, MD. Rationale: “Per Official Disability Guidelines, Neck and Upper Back MCG version (Last review/update date: X), X, "ODG X Guidelines, Sprain or strain of neck: X ." In this case, Per the reviewed records, this claimant sustained a work-related neck injury secondary to X on X. The cervical spine CT on X showed no significant abnormality. Treatment to date includes X as of X. Per the PT note on X, the cervical spine pain was unchanged at X on the numeric pain scale. This was the same as the pain rating at the initial X visit on X. In terms of the X, the claimant had made X progress towards the goal for the cervical spine left rotation, improved from initial value of X degrees to current X degrees, goal was X degrees. The cervical spine examination revealed continued tenderness to trapezius muscle bilaterally, active flexion and extension within normal limits, and diminished side bending, left greater than right. At the office visit on X with Dr. X, the claimant reported that X saw the X who told X that X concussion symptoms should resolve on their own and that X headaches could be secondary to the neck, and recommended magnetic resonance imaging (MRI). The claimant stated that X had not yet had cervical spine/neck therapy and was referred for X. However, the provided medical records contradict that statement and documents that the claimant has completed X. The office notes on X did not document a cervical spine examination and did not show any objective deficits such as loss of range of motion to support the request for treatment. The prior request for X was noncertified on utilization review dated X on the basis that the patient has completed X. I agree with the prior determination. ODG recommends X. The last documented examination on X showed near X. No extenuating factors are noted to support this request. Thus, this request for X is not medically necessary and not certified.”

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the submitted documentation, the prior determinations are accurate. The ODG recommends X. The last documented examination on X showed near X. No extenuating factors are noted to support this request of ongoing X. Medical necessity cannot be established given the associated medical records. No new information has been provided to overturn the prior denials. X is not medically

necessary and non-certified.

Non-certified.

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)**