

P-IRO Inc.
An Independent Review Organization
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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 Overturned Agree in part/Disagree in part
- Upheld Agree

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X injured X neck while X. The weight was unloaded, causing a sudden twisting, turning neck motion when X initially felt impulse pain in X left shoulder. Later that evening, tightness with numbness and tingling in the X were noted. The diagnosis was unspecified sprain of the left shoulder joint, initial encounter (X).

X was seen by X, DO, from X through X. On X, X was seen for severe neck, left shoulder, and arm pain associated with decreased range of motion, numbness, and tingling in the X of X left hand, all following a work injury. X continued to experience moderate to severe pain despite X. X X score was X and GAD-X score was X, indicating mild anxiety. Poor sleep was reported. At the time, the neck and arm pain were rated at X. The pain was worse with coughing, lifting, and with sudden movement of X neck. On examination of the cervical spine, there was a X. X had marked decreased left rotation at X degrees and right rotation at X degrees. X could bring X. There was decreased pinprick in the X. X were noted in the neck and left shoulder. Drop arm test was X. Internal rotation and external rotation of the shoulder did not cause pain. The assessment included X.

Treatment plan was to proceed with X. Due to X and fear, X would require X. On X, X was seen for a follow-up. X continued to have moderate to severe left shoulder and arm pain. In addition, X had a X in X neck from the work injury, which was contributing to X left shoulder pain. As a direct result of the left shoulder pain and X; Dr. X recommended X. Once again, X had decreased neck range of motion and moderate interspinous tenderness. X had a range of motion of only X about X left shoulder. On X, X continued to report marked left shoulder, neck, arm, and hand associated with X. X had X across X triceps and grip strength.

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They were waiting for approval of X. Dr. X planned to use a X, which would then allow them to target the X. Due to X status and large body habitus, X would require X.

An MRI of the cervical spine dated X showed discogenic changes within the cervical spine, most pronounced on the left side at X. There was a left X. Disc material 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: “ Regarding X, the Official Disability Guidelines recommend this X. There should be failure to respond to X. Lastly, the guidelines do not recommend X. A phone call to the office of X, D.O., at X was attempted on X at X to request the specific approach to be used for requested X. The office was closed and there was no option of leaving voicemail. Per submitted documentation, the request is not warranted. The guidelines recommend X. The injured worker presented with severe neck, left shoulder, arm pain associated with decreased range of motion, numbness and tingling in the X of their left hand. Objective findings showed X. The provider recommended X due to the injured worker X. Although the clinical and MRI findings showed indication of X, the request is not supported as the approach to be used for the X is not indicated. Furthermore, although the injured worker was classified as X, the requested X is not recommended due to the necessity for them to remain communicative and able to report symptoms during the procedure. Therefore, the X is noncertified.”

Per a reconsideration review adverse determination letter dated X, the prior denial was upheld by X, DO. Rationale: “Based on the submitted documentation, the request for X is not warranted. The referenced guideline recommends the request to treat X. The X must be performed at X. There must be a failure to respond to greater than or equal to X weeks of X, as indicated by the use of X. However, X is not recommended, while the use of X is also not recommended.

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The injured worker presented with neck and arm pain, along with a X Spurling's test with impulse pain into the left shoulder, limited ROM, decreased sensation to pinprick in the X. Furthermore, the provider prescribed X due to the injured worker having X. The presented MRI also revealed a X. The prior non-certification under review X was because the approach to be used for the X was not indicated and X being not recommended by the cited guideline it was necessary for them to remain communicative and report symptoms during the procedure. In this case, the request is still not medically necessary as there is no evidence of X. Moreover, X seems to be too far below the affected X. As a result, the appeal request X is non-certified."

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

Based on the records for review, X continued to report marked left shoulder, neck, arm, and hand associated with X. X had X weakness across X triceps and grip strength on X, An MRI of the cervical spine dated X showed X. Disc material X as well, which could be associated with X.

X has neck pain with X. The patient has X. Therefore the request should be certified with X. The guidelines recommend X. X is medically necessary and certified.

Certified.

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)

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- 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