



MedHealth Review, Inc.
422 Panther Peak Drive
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES:

IRO CASE #:

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

The reviewer is a Medical Doctor who is board-certified in X

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of X

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X with a reported date of injury of X. The mechanism of injury was not provided. Identifiable comorbidities included a BMI of 31.56, atrial fibrillation, Type II diabetes, depression, anxiety, and use of anticoagulants. Documented medications include X. Prior treatments have included X.

Radiology report MRI of the cervical spine without contrast dated X demonstrates multilevel cervical spondylosis, most significant C4-C5, causing severe bilateral foraminal and severe spinal and severe spinal stenosis with cord impingement and focal associated myelomalacia. At C3-C4 there is a severe right, moderate left foraminal, and moderate spinal canal stenosis. At C5-C6 there is severe right, mild left foraminal, and mild moderate spinal canal stenosis. At C6-C7, there is moderate bilateral foraminal and mild spinal canal stenosis. At C7-T1 there's moderate right and mild left foraminal stenosis. The operative report dated X notes that the claimant underwent X.

Follow up visit dated X patient presents with persistent moderate to severe neck, right shoulder, arm, and hand pain. The claimant is on a combination of a weak narcotic and neuropathic pain medication. The claimant is continuing X care as advised. The claimant is receiving medications without side effect, which includes a combination of neuropathic and weak narcotic analgesia. Today, the claimant has moderate mid cervical interspinous tenderness, decreased range of motion in the neck, weakness in the left arm. The claimant has anterior cervical discectomy and fusion from C4-C6 and the provider recommend X approach. The claimant is on X due to ongoing a fib, and non-insulin dependent diabetes claim advise X care with X.

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

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition

Per evidence-based guidelines, and the records submitted, this request is non-certified. Regarding X may be indicated when all of the following are present: pain with the duration of at least four weeks, cervical radiculopathy by history and numbness along the distribution of the affected spinal area, and all of the following: diagnostic imaging that correlates with symptoms. X; failure to respond to at least four weeks of conservative care as indicated by all of the following non-steroid anti-inflammatory drugs, physical therapy, or documentation of patient intolerance of physical therapy. The procedure must be performed under X. In this case, records do not show a description of radicular pain in a dermatomal pattern related to the requested cervical level. There's no current evidence of neurological compromise in the dermatome or myotomal distribution consistent with C7 to T1 radiculopathy. Therefore, X is not medically necessary.

**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**
- 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 JUDGEMENT, CLINICAL EXPERIENCE
AND EXPERTISE IN ACCORDANCE WITH
ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE
GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES &
TREATMENT GUIDELINES**
- PRESSLEY 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)**