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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

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☐ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X when X was X. The diagnosis was cervical spondylosis and muscle spasm.

On X, X was evaluated by X, MPAS, PA-C for neck pain. X presented with X. X pain had primarily been axial with some radiation towards the left greater than right upper trapezius. X underwent X on X at X and X and reported X pain relief that day. X was scheduled for X on the right side at X and X on X. X pain increased with daily activities of standing, looking down, and doing dishes. X denied any upper extremity radiation. Cervical MRI in X was significant for X. Multilevel moderate-to-severe X was also seen. At the time, X was not using any medication for pain and rated X pain a X at the time. Cervical spine examination revealed X. Range of motion of the neck revealed X. X was present bilaterally throughout the cervical spine. There was X to palpation along the left trapezius. The assessment was X. It was noted that

An MRI of the cervical spine dated X, demonstrated X. There were multilevel mild-to-moderate X. There was X. Moderate X. X was seen at

X. Findings were concerning for X. There was X. X-rays of the cervical spine dated X, identified a X. There was X. X with an intact plate and well X. No motion was demonstrated at the site of the spinal fusion. In flexion, there is a X. The prominent X. In neutral, a X was seen. In flexion, there was a X. In extension, there was a X. Narrowing with significant X were noted involving the X. In the AP image, there was a significant 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 states X. Planned procedure is indicated if the initial diagnostic fluoroscopically guided X are necessary to diagnose X. In this case, the current request for request form authorization is X where the specific anatomic level is not documented. In addition, the records do not support that the claimant has completed a X. 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: "ODG states X. Planned procedure is indicated if the initial diagnostic fluoroscopically guided X. In this case, the claimant reports axial cervical spine pain that has X. Range of motion of the neck is limited in extension. Facet loading is X. Neurological examination is X. The records support that the claimant underwent X. The records document successful response of X. Given the claimant's presentation which supports X. As the request does not include the specific targeted levels, and considering the levels addressed during the X. However, there was no opportunity for

discussion with agreement to modification. Therefore, the requested X is not medically necessary."

Thoroughly reviewed provided records including provider notes and peer reviews.

The patient had two successful X. Proceeding to X is warranted at this juncture based on cited guidelines. While the request may not have specified the levels for X medically necessary and certified. X not medically necessary and non-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 and peer reviews.

The patient had X. Proceeding to X. While the request may not have specified the levels for X. X is medically necessary and certified.

Certified

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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

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