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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X; Amendment X; Amendment X; Amendment X; Amendment X:Amendment X: Amendment 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. X was injured when X was X. The diagnoses were cervicalgia, cervical disc disorder with radiculopathy, unspecified cervical region; other cervical disc displacement, unspecified cervical region; and spondylosis without myelopathy or radiculopathy, cervical region.

On X, X was seen by X, MD for follow-up evaluation of neck / cervical spine pain. The pain persisted, and it was taking longer for the numbness to subside. X continued to experience significant pain in X neck, shoulder, and down X right arm, accompanied by numbness and tingling extending into X fingers. X had a history of X. X had previously undergone X. X had been dealing with these symptoms for approximately X. X has been managing this condition under Workers' Compensation, which had complicated the approval process for further treatment. On examination, there was limited range of motion of the cervical spine. There was X. There was a X on the right side and a X on the left side. There was diminished grip strength on the right side. There was diffusely diminished pinprick sensation in the right hand compared to the left. The MRI showed a X. Dr. X assessed that X had X. X was recommended for X. They would X. On X, X was seen by X, NP for follow-up evaluation for chief complaint of neck pain. X presented for follow up of X cervical spine pain. X was last seen in X and X; however, it was denied by Workers' Compensation due to X. At the time, X had X and returned on the day for re-evaluation. X reported X had better range of motion of X neck and right shoulder; however, the pain continued in X neck and radiated into X right upper extremity to X hand. X reported worsening numbness / tingling in X right upper extremity. X also reported new onset right lower extremity numbness / tingling, had X. X continued to take an X. X denied any bowel or bladder incontinence. On the day, X rated pain X. Physical examination revealed X. Bilateral upper extremity range of motion was X

. Bilateral upper extremity muscle tone and strength were X. X was X. It was noted that at this point,
X had completed a X. A X was still recommended. They would resubmit to Workers' Compensation and once approved, would begin the scheduling process. On X, X, MD placed a request for X.

X-rays of the cervical spine dated X, revealed it was X. A CT scan of the cervical spine dated X revealed a X. Left neural foraminal stenosis at the X was noted. An MRI of the cervical spine dated X, revealed X. There was X. Anterior and posterior vertebral body osteophytes were most notable at X. Loss of X was noted. Multilevel degenerative changes of the cervical spine, most notable at the X was noted. At the X, there was X. At the X, there was X. At the X, there was X. At the X, there was X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, and a peer review report dated X, the request for X: "The current physical exam did not detail evidence of progressively worsening neurological deficits in the upper extremities to support proceeding with surgical intervention. There was no weakness, sensory loss, or reflex change noted. No pathological reflexes were described. Further, there is an inconsistency noted in the claimant's reported smoking in the clinical records. It is unclear if the claimant had discontinued smoking. Given these above noted issues, certification for the X is not recommended. As the X is not indicated, there would be no requirement for a X.
Therefore, the X is not medically necessary." Rationale for denial of X: "The request is not medically necessary as the X is not indicated, there would be X." Rationale for denial of X: "The request is not medically necessary. As the X is not indicated, there would be X." Rationale for denial of X: "The request is not medically necessary. As the X is not indicated, there would be X. Additionally, the current ODG does not recommend X."

Per a utilization review adverse determination letter dated X, and a peer review report dated X, the request for X was denied by X, MD. Rationale for denial of X: “Review of the claimants most recent clinical evaluation found no evidence of any specific X. There was no evidence of X. The claimant’s current physical exam findings do not support the X. Given these issues which do not meet guideline recommendations, this reviewer cannot recommend certification for the request. As the X is not indicated, there would be no requirement for a X. Therefore, the request for X is not medically necessary.” Rationale for denial of X: “The request is not medically necessary. This is secondary to the requested X that is not approved. Therefore, the request for X is not medically necessary.” Rationale for denial of X: “The request is not medically necessary. This is secondary to the requested X that is not approved. Therefore, the request for X is not medically necessary.” Rationale for denial of X: “The request is not medically necessary. This is secondary to the
requested X that is not approved. Therefore, the request for X is not medically necessary.”

Per a utilization review adverse determination letter dated X, and a peer review report dated X, the request for X was denied by X, MD. Rationale for denial of X: “This is an appeal of a previous denial which noted "Review of the claimant’s most recent clinical evaluation X. There was no evidence of X. The claimant’s current physical exam findings do not support the X." The X clinical evaluation did not identify X. There was X. There is no evidence of X. Given these issues which do not meet guideline recommendations, this reviewer cannot recommend certification for the X. As the X is not indicated, there would be no requirement for a X. Therefore, APPEAL X is not medically necessary.” Rationale for denial of X: “The request is not medically necessary. As the X is not indicated, there would be X.” Rationale for denial of X: “The request is not medically necessary. As the X is not indicated, there would be X further, ODG does not recommend X.”

The requested X is not medically necessary. The submitted medical records do not X. The records also reflect that the patient is an active tobacco user. The use of a X is not supported for a X. No new information has been provided which would

overturn the previous denials. 1) X, 2) X 3) X are not medically necessary and non-certified

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

The requested X is not medically necessary. The submitted medical records do X. The records also reflect that the patient is an active tobacco user. The use of a X is not supported for X. No new information has been provided which would overturn the previous denials. 1) X,
2) X 3) X are 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:

- ☐ 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)