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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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X was moving a X. The diagnosis was sprain of ligaments of cervical spine, initial encounter (X).

X was seen by X, DO, on X and X. On X, X was seen for chronic persistent severe neck pain radiating into X left greater than right arm associated with headaches, numbness, tingling, poor memory, and left eye drop all following a concussive head injury. X also noted ringing in the left ear, vasomotor instability including redness in the left eye, and occasional nasal congestion. The pain score was X-X. X X score was X, consistent with moderate reactive depression and anxiety associated with this injury. X GAD-X score was X. On examination, there was tenderness over the posterior occipital vertex cranium with reproduction of soft tissue pain. X additionally had marked left cervical facet tenderness at X and X. There was interspinous tenderness at X and X, worse with flexion and looking overhead. X were noted in the neck and upper back area. X were noted extending into the interscapular and rhomboid regions with jump signs elicited. X did have mild anisocoria and conjunctival redness on the left as compared to the right. Spurling testing was X for impulse pain in the left shoulder. The assessment included X. Initial medical management would include further X. The mainstay of care however would include a X. X would require X to provide a still safe surgical field. On X, X was seen for X. As a result, X was recommended. Further delays in this treatment would only lead to more refractory and costly pain complaints. X had X. X MRI had been corroborated to include a X. X had tenderness at this site, pain with coughing and sneezing was consistent with X. X did have radiating pain into both arms and hands, left greater than right. A X was recommended. Further delays in this treatment would lead to a refractory and costly pain complaint.

An MRI of the cervical spine dated X showed a X. At X. At X. At X. At X. Facet joints were unremarkable with patent spinal canal and foramina.

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, ODG states that X. There should be X. In this case, the review of the clinical documentation does X. There is no evidence of

X. Furthermore, there is no evidence of the X. As such, the medical necessity of X, is not established. Since the medical necessity of X is not established, the medical necessity of X is also not established. Therefore, this request is not medically necessary. Recommendation is to deny this request.”

Per a reconsideration review adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: “Within the medical information available for review, there is documentation that a prior adverse determination was rendered due to X. In addition, there is documentation X. Furthermore, there is documentation that the patient has X. Lastly, the requesting provider notes that a X is recommended, that delays in this treatment will only lead to more refractory and costly pain complaint, that patient has X. However, there continues to be no documentation of X. In addition, despite documentation that a X is recommended with X in the prone position to provide a still safe surgical field; the proposed X at levels above X or X are not recommended. Medical necessity HAS NOT been established, therefore, the request is non-certified.”

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

The request for X is not recommended as medically necessary and the previous denials are upheld. In this case, there is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is no significant X on MRI. X dated X demonstrates X. At X, there is a X. X, there is X. At X, there is X. At X, there is X. X are unremarkable, and X is patent. At X, there is X. X are unremarkable with X. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no documentation of a X. Also, guidelines do not typically support X. Therefore, medical necessity for X is not established in accordance with current evidence-based guidelines and is not medically necessary.

Upheld

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
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE