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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)

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 sustained an injury on X. X was in the back of the X. X associate X. X head was in a forward flexed position when this event occurred. X developed memory deficit, difficulty concentrating, headaches on almost a daily basis, and pain in left neck, shoulder, and arm. The diagnoses included chronic neck pain syndrome associated with neck sprain / strain; cervicogenic headache; and postconcussion head syndrome.

X was seen by X, DO on X for neck pain. X first X got X excellent relief of pain and improved function and range of motion. X numbness and tingling was nearly completely gone in X left and right arm and hand. X continued to complain of neck pain with stiffness particularly at night. On examination, X had some X. The plan was for X.

On X, X presented to Dr. X expressing anxiety and worry as X neck pain had not been completely relieved. The X was more than X effective in alleviating X pain, improving X range of motion, less numbness and tingling. X continued to have headaches associated with tension headaches. X noted almost complete resolution of X arm and hand pain on the left; however, X had difficulty looking to the right and continued to have moderate neck pain. The plan was for X.

An MRI of the cervical spine on X showed X. There were X. Disc material also herniated anteriorly, most pronounced at X, and X, which could be associated with disc instability.

Treatment to date included X.

Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: "Per submitted documentation, the request is not warranted. A similar review on file for X was certified under X on X as the requested X is needed for alleviation of pain and inflammation, thus increasing functionality and a better quality of life. The referenced guidelines recommend X. X are indicated only when there is documentation of sustained improvement of at least X for X weeks after the X, recurrence of pain or functional decline, and fewer than X sessions in a X-

month period. The guidelines also specify that X are not recommended. Based on the injured worker's clinical findings, the X performed on X resulted in excellent relief of pain, improved function, increased range of motion, and near-complete resolution of numbness and tingling. The subsequent progress report dated X documented only X. There is no documentation of sustained pain or functional decline after the X, which is required for X. Furthermore, the request includes X, but the guidelines advise against using X. Since the injured worker demonstrated sustained improvement and resolution of radicular symptoms following the X. The request is therefore not medically necessary to provide additional benefit. Therefore, the prospective request for X is non-certified.”

Per the appeal review by X, MD on X, the request for X was non-certified.

Rationale: “The ODG recommended X. X were indicated only when there was documentation of sustained improvement of at least X for X weeks after the X, recurrence of pain or functional decline, and fewer than X sessions within a X month period. It further recommends performing the procedure under X. The guidelines, however, also specified that X. Based on the injured worker s clinical findings, the X performed on X resulted in excellent pain relief, improved function, increased range of motion, and near complete resolution of numbness and tingling. The progress report dated X documented X. There was no indication of sustained pain or functional decline following the X, which was required for a X. Additionally, the current request included X, which the guidelines advised against. The appeal letter dated X also did not confirm recurrence of radicular pain or functional decline. Since the injured worker demonstrated sustained improvement and resolution of radicular symptoms without documentation of worsening pain or function, the clinical findings did not meet guideline recommendations for a X. Therefore, the appeal request for X is noncertified.”

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

In this case, based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld.

The ODG recommended X only when radicular pain persisted for at least X

weeks, imaging findings correlated with symptoms, the X was performed at X. X were indicated only when there was documentation of sustained improvement of at least X for X weeks after the X, recurrence of pain or functional decline, and fewer than X sessions within a X-month period. It further recommends performing the X. The guidelines, however, also specified that X.

Based on the injured worker's clinical findings, the X. The subsequent progress report dated X documented X. There is no documentation of sustained pain or functional decline after the X, which is required for X. Furthermore, the request includes X, but the guidelines advise against using X. Since the injured worker demonstrated sustained improvement and resolution of radicular symptoms following the X.

Therefore, medical necessity of the request 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:

- 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)