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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 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 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. The mechanism of injury was described as X. X was in the, X. There was no loss of

consciousness. The diagnosis was acute nonintractable headache, unspecified headache type (X); concussion without loss of consciousness, initial encounter (X); strain of neck muscle, initial encounter (X); trapezius strain, left, initial encounter (X). On X, X followed up with X, PT for a X visit for the diagnosis of concussion without loss of consciousness, initial encounter (X). This was X. X reported having intense headache of the right-sided neck, radiating into the right orbital region, X in intensity. X could perform activities of daily living independently but could not perform recreational activities independently. X reported X had been performing X. X had been given work restrictions by X treating medical provider, which limited X participation in one or more essential job functions. X reported being unable to participate fully in one or more community or life events due to impairments associated with ongoing injury. It was noted X had reached X of X functional goal at that visit. Continued assessment was required for anticipated visits required for discharge. Cervical left rotation active range of motion (AROM) was X degrees, with goal X achieved. The assessment was X. It was assessed that X overall progress was as expected. X reported having reduced X intensity in headache post manual treatment. In addition, pain was no longer present behind the right eye, centralized to the right-sided neck. It was recommended that X continue X per the treatment plan. X was performed to the X. Per an undated X visit note signed on X, by X, PT, X had completed X. X was seen for the diagnoses of trapezius strain, left, initial encounter (X); strain of right trapezius muscle, initial encounter (X); and strain of neck muscle, initial encounter (X). X reported X was X of the way to a full recovery and reported X headaches were still the most limiting factor. X continued to take pain medication to manage X headaches. X could perform activities of daily living independently but could not perform recreational activities independently. X reported being unable to participate fully in one or more community or life events due to impairments associated with the ongoing injury. X had been given restrictions by X medical provider which limited X participation in one or more essential job functions. It was assessed that X had shown significant progress on X. X continued to X. X continued to be heavily X. X headaches had remained to present as if they were musculoskeletal in nature, and they had responded well to X. Additional X was needed to address impairments in AROM and pain in order to tolerate functional requirements for full work duties. X was recommended X times a week for X weeks. X had reached X of X functional goal at that visit, with cervical left rotation ongoing value of X

degrees, with goal X achieved. Lift, carry, push / pull goals were X achieved. On X, X was evaluated by X, MD for follow-up on headache, left knee, and left ankle. X had been working modified duty. X reported X was in the X. There was no loss of consciousness. X reported the left leg was flexed when X landed, which caused abrasion to the left knee and ankle. X also had abrasion to X right ring finger. X stated X had seen a X who advised X concussion symptoms should resolve on their own and X felt the headaches' origin could be a cervical spine and advised an X. A discussion with X that day revealed X had not had X. Dr. X would order X. X asked about work restrictions and Dr. X stated the expected time to return to work would be by the end of the month. Examination findings were within normal limits. It was noted X was X of the way toward meeting the physical requirements of X job. The assessment was X. A X referral was provided, X times a week for X weeks, for strain of neck. It was noted X was medically necessary to address clinical impairment / functional loss and to expedite return to full activity. The ongoing restrictions were continued, to include no lifting / carrying, sedentary work only, and may not room patients as this was not sedentary work. A X dated X, demonstrated X. There was X noted. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "The request is not medically necessary. In this case, the claimant has pain, extension at X degrees, side bend at X degrees on the right and X degrees on the left, right rotation at X degrees and left rotation at X degrees, X. The claimant has had X for the cervical spine. Guidelines recommend X. The quantity exceeds guidelines. Therefore, the X is not medically necessary. "In a letter dated X, by X, "This is a request for X. The medical provider, Dr. X, has requested this medical treatment because there is an ongoing condition(s) that requires treatment, the recommended treatment relieves the effects of a compensable injury; and the recommended treatment promotes recovery. The goal of this reasonable and medically necessary treatment, which is consistent with the ODG, is to provide pain relief, increase performance in the activities of daily living, reduce claimant's symptoms, and reduce medication use. The medical records establish the clinical indication and necessity of this procedure. "Per a reconsideration review adverse determination letter dated X, the appeal request for X, was denied by X, MD. Rationale: "Per Official Disability Guidelines, Neck and Upper Back MCG version (Last review/update date: X), X." In this case, Per the reviewed records, this claimant sustained a work-related neck injury secondary to

X on X. The X on X showed no X. Treatment to date includes X to X as of X. Per the X note on X, the cervical spine pain was unchanged at X on the numeric pain scale. This was the same as the pain rating at the X visit on X. In terms of the cervical spine X, the claimant had made X progress towards the goal for the cervical spine left rotation, improved from initial value of X degrees to current X degrees, goal was X degrees. The cervical spine examination revealed X. At the office visit on X with Dr. X, the claimant reported that X saw the X who told X that X concussion symptoms should resolve on their own and that X headaches could be secondary to the neck, and recommended X. The claimant stated that X had not yet had X and was referred for X for the neck muscle strain X times per week for X weeks. However, the provided medical records contradict that statement and documents that the claimant has completed X sessions of X for the neck with significant improvement and had near normal range of motion on X. The office notes on X did not document a X. The prior request for X was noncertified on utilization review dated X on the basis that the patient has completed X for the cervical spine, and guidelines recommend X visits for cervical sprain. I agree with the prior determination. ODG recommends X for neck sprain, and this patient has already completed X. The last documented examination on X showed X. No extenuating factors are noted to support this request. Thus, this request for X is not medically necessary and not certified.”

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

Based on the submitted documentation, the prior determinations are accurate. The ODG recommends X for neck sprain, and this patient has already completed X. The last documented examination on X showed X. No extenuating factors are noted to support this request of ongoing X. Medical necessity cannot be established given the associated medical records. No new information has been provided to overturn the prior denials. X is not medically necessary and non-certified.

Non-certified.

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)