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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:

- Upheld
- Overtured
- Partially Overtured

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured at work on X. X was X. The diagnosis was cervical radiculopathy and myelopathy; cervical disc displacement, X; cervical stenosis, X; bilateral hand numbness; bilateral shoulder pain; mild bilateral carpal tunnel syndrome; at X, there was a X disc-osteophyte complex and bilateral facet hypertrophy and bilateral uncovertebral joint hypertrophy producing central stenosis with mid sagittal spinal diameter reduced to X as well as moderate bilateral X foraminal stenosis. At X, there was a X disc-osteophyte complex and bilateral facet hypertrophy and bilateral uncovertebral joint hypertrophy producing central stenosis with mid sagittal spinal diameter reduced to X as well as severe bilateral foraminal stenosis.

On X, X, MD, saw X for a follow-up evaluation. X complained of neck pain, bilateral trapezial pain, bilateral arm pain, and numbness and tingling in both hands. Both handgrips felt weak. X had neck pain on a daily basis. It was constant and rated X. It increased with looking up and with neck movements. It affected X sleep as well as activities of daily living and quality of life. X neck movements were very restrictive. X used a heating pad. X also complained of bilateral shoulder pain, especially when lifting X arms. X had been working light duty. MRI of the cervical spine from X, was reviewed. On X, X underwent a X. X also went to X. X continued to work light duty. X continued to complain of neck pain, bilateral arm pain with numbness and tingling. Complete neurological examination demonstrated X. X had slight tenderness to palpation to the posterior cervical spine and bilateral trapezii. X was tender to palpation over both shoulders laterally and posteriorly. Range of motion of the cervical spine revealed flexion X degrees, extension X degrees, and rotation of X degrees to the left and to the right. Sensory examination revealed hypesthesia to digits X bilaterally. Right triceps reflex was absent. There was some spread to finger flexors on biceps reflex testing suggesting myelopathy. Tinel's was X on the left and right wrists. The assessment was cervical radiculopathy and myelopathy; cervical disc displacement, X and X; cervical stenosis, X and X; bilateral hand numbness; bilateral shoulder pain; mild bilateral carpal tunnel syndrome; at X, there was a X disc-osteophyte complex and bilateral facet hypertrophy and bilateral uncovertebral joint hypertrophy producing central stenosis with mid sagittal spinal diameter reduced to X as well

as moderate bilateral X foraminal stenosis. At X, there was a X disc-osteophyte complex and bilateral facet hypertrophy and bilateral uncovertebral joint hypertrophy producing central stenosis with mid sagittal spinal diameter reduced to X as well as severe bilateral foraminal stenosis. Dr. X noted X symptoms were most consistent with a cervical stenosis at X. X had X. Treatment options were discussed. X wanted to proceed with surgery. X was a candidate for a X. A X was ordered for preoperative surgical planning. X light duty work status was continued.

An MRI of the cervical spine dated X, demonstrated multilevel degenerative changes of the cervical spine, most pronounced at X and X where there was moderate spinal canal stenosis. There was moderate bilateral neural foraminal narrowing at X and severe bilateral neural foraminal narrowing at X. There were mild reactive fibrovascular endplate changes at X and X and to a lesser extent X. EMG / NCV studies dated X, were X. There was X. There was 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: "Per ODG, Neck and Upper Back Chapter, MCG version (updated X), X." The claimant has neck pain. Physical exam revealed cervical flexion and extension X, left and right rotation X, absent right biceps reflex, hypesthesia to digits X bilaterally, and X Tinel's at the wrist bilaterally. It is noted the claimant's symptoms are most consistent with a X. However, there is no documentation that the X is authorized, therefore a X is not necessary. This request is not certified."

In a letter dated X, Dr. X wrote to appeal the denial of authorization for a X. Since the work-related injury on X, X had been experiencing persistent neck pain radiating to both arms, numbness and tingling in X hands, and significant functional impairment. The pain was constant, worsened with neck movement, and interfered with sleep and daily activities. MRI on X, revealed X. Clinical examination revealed X. Failed X included X that worsened symptoms; X; and ongoing pain despite medications and activity modification. Quoting the Official Disability Guidelines, for neck and upper back, anterior cervical fusion, Dr. X noted

that X met the following guideline criteria: Imaging confirmed X. The denial cited lack of documented failure of non-operative measures and absence of progressive neurological deficits. However, X records and clinical notes confirmed X worsened pain. X failed to provide relief. Neurological deficits (absent triceps reflex, sensory loss, signs of myelopathy) were documented. X continued to work light duty due to pain and functional limitations. Dr. X requested reconsideration and approval for X, stating, "This X is medically necessary to relieve severe pain, restore function, and prevent further neurological compromise."

Per a reconsideration review adverse determination letter dated X, the appeal request for X is medically necessary was denied by X, MD. Rationale: "The request is not medically necessary. In this case, the request for X was recently non-certified noting that the records did not document X. X records for the claimant were included for review detailing response and lack of progress with treatment. Review of the claimant's current evaluation did not X. X was noted. There was equivocal evidence of radiculopathy on the most recent electrodiagnostic study. Therefore, APPEAL X is not medically necessary."

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

In this case, the submitted documentation demonstrates that the patient already had an MRI scan of the cervical spine dated X. Further imaging is not supported. In addition, there is no documentation provided to demonstrate that the requested X has been approved and therefore a X is not indicated for surgical planning purposes. No new information has been provided which would overturn the previous denials. The requested X 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
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)