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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 involved in work-X. At the time of the incident, X was the X. X also had continued pain rated X in the neck, thoracic and lumbar region, left shoulder, left hip, head, and left knee described as sharp and slightly worse than the

prior visit. X complaints interfered with lifting, employment, personal care, and sleeping. Examination remained unchanged from the prior visit dated X. The assessment included X. X prognosis was X. Dr. X noted that with regard to X treatment plan, the request for X was denied. The denial was based on an incorrect application of ODG guidelines and failed to account for X multiple documented injuries. X had sustained injuries to multiple body regions, including the cervical spine, lumbar spine, thoracic spine, shoulder, hip, and knee. The peer reviewer incorrectly applied a X. This was medically inaccurate, as ODG guidelines provide recommendations per body region, not as a X. The denial also overlooked objective findings, including documented muscle spasms, tenderness, and a X Spurling's test, all supporting the need X. The requested X was reasonable, conservative, and medically necessary, especially given the extent of injury. Denial of care placed X at risk for worsening symptoms, chronic pain. and increased need for invasive treatment. The plan was to request X. Other treatment recommendations included follow-up with X.

An MRI of the cervical spine (without contrast) dated X demonstrated X. There was a X. Additional findings included X. X was identified. An MRI of the lumbar spine (without contrast) dated X demonstrated X. At X, there was a X. At X, there was X. No X was noted. Findings were consistent with X. An MRI of the brain (without contrast) dated X demonstrated X. There was X. Ventricular size and configuration were X, and X. X was noted within the X. Overall, the study was unremarkable for X.

Treatment to date included X.

Per an initial utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “Based upon the medical documentation presently available for review, Official Disability Guidelines would not support a medical necessity for this specific request as submitted. For the described medical situation, the requested amount of treatment in the X. As a result, presently, medical necessity for this specific request as submitted is not established. Attempts at conducting a X.” “Determination: NON-AUTHORIZED. Criteria: X. "X: X. X: "X. Pursuant to the requirements of X, I affirm that I am of the same or similar specialty as the physician who requested, ordered, or is to provide the health care service that I have reviewed Per CMS Guidelines, treatment past X minutes requires documentation substantiating the medical necessity of the additional time. X, there

must be documentation to support the medical necessity. Over the course of X. In addition, X."

The initial adverse determination letter dated X also noted, "These are the disputes we have received from the adjuster: X. We don't agree because: We are disputing entitlement of X: Per your recorded statement on X, you reported that you were initiating a X. You stated the X. You indicated that the X. The X. You reported that you sustained injuries to your left knee (swelling), left palm (swelling/bruising), front of head (bruising/swelling), bottom lip (swelling), right ribs (soreness/no physical injuries), left ribs (soreness/no physical injuries), lower back (bruising), concussion, right/left shoulder (tightness/bruising), neck (stiffness/no physical injuries), bilateral leg (numbness/tingling), right eye (pain), headaches, back of head on right side (tenderness), neck (stiffness), muscle fatigue and weakness, left hip (pain/bruising), and middle spine (pain). The carrier has accepted and will pay benefits related to X only. The above disputed condition is pre- existing, personal in nature, an ordinary disease of life and/or not considered work related. Mere pain, without damage or harm to the physical structure of the body, does not constitute an injury under the Texas Workers' Compensation Act. There is no evidence establishing X. There has been no worsening, acceleration, and/or aggravation of any pre-existing conditions, as it relates to the X compensable injury. Therefore, we have not received, nor have you provided, any evidence to support the above disputed diagnosis/symptom occurred as a result of your employment with X. X disputes compensability of any other area of the body that has not explicitly been addressed by the claimant to X and / or its specified representatives."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD who had non-authorized the reconsideration and noted it was not medically necessary. Rationale: "The Official Disability Guidelines state that X is recommended for the treatment of cervical and lumbar sprain. The recommended X. Additional X may be indicated when there is functional progress. The claimant has complaints of neck and lower back pain that was rated at X. The claimant also reported that the symptoms affect daily function, self-care, and work. The pain also worsens with prolonged walking, using the stairs, and lifting. Assessment showed presence of X, presence of X in the left hip, left shoulder, and left knee, moderate swelling palpated in the neck and lumbar areas, normal gait, moderate pain upon palpation of neck and lumbar spine, presence of moderate

trigger points and muscle spasm, moderate limited range of motion, X Spurling test, X straight leg raises, X Hawkins, X sensation to light touch, and X reflexes. Prior treatments include X. Per treatment history, there was a X for the X dated X. The provider now requests X. This case was previously noncertified as the request went beyond the guideline's recommendation. X information given. However, the request remains unsupported as it has already X. There was also X. Therefore, the medical necessity has not been established for X." Per an addendum, "A call was made to X on X the provider was not available left a message with the front desk staff for X, MD. At the time of submission, no calls had been received. Determination: NON-AUTHORIZED. Screening Criteria and Treatment Guidelines: X."

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

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records indicate that the patient has been X. The Official Disability Guidelines X. The current request exceeds guidelines. When X the guidelines, X should be noted. There X documented. Therefore, medical necessity for X is not established in accordance with current evidence-based guidelines and denials are upheld.

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