True Decisions Inc.
An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #615
Mansfield, TX 76063
Phone: (512) 298-4786
Fax: (888) 507-6912
Email: @truedecisionsiro.com

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, while working in a X. X described that the X. X then described the situation where, upon exiting the X, X misjudged the hypertension of

the X, resulting in a X. The diagnosis was chronic neck pain syndrome following closed head injury consistent with postconcussion head syndrome and spinal shock following axial loading with twisting mechanism of injury; cervical disc disruption with chemical irritation of the cervical column with secondary myofascial pain of the neck and upper back area; cervical mechanical neck pain syndrome of the facet joints.

X was seen by X, DO on X, for an initial pain evaluation with a chief complaint of chronic persistent head and neck pain radiating into X left shoulder following a traumatic injury with head contusion, cervical strain / sprain per the initial Workers' Compensation diagnosis on X. Examination findings showed X to be in moderate distress related to the chief complaint. X had a X. Flexion of the cervical spine X degrees reproduced X neck pain. X did have interspinous tenderness extending from X down to X. X had some X. X in the neck and upper back area were noted. Based on response to this care, further treatment of X. Dr. X discussed the above findings and recommendations with the patient. X wanted to proceed with X. Due to X, X would require X. Per a progress note dated X, X, DO, noted that X was eagerly waiting to go ahead with X. X had X. X MRI had been X. The X had been reversed consistent with the axial flexion and loading injury X sustained while at work on X. X had exhausted X. X did have a postconcussion head injury with closed head injury initially diagnosed but due to the persistent nature of X neck pain, stiffness, Dr. X was recommending X. This X which X continued to suffer from including occasional headache, stiffness, numbness into both shoulders and neck areas. X did have radiating pain through the right shoulder as well. X often was helpful in hastening this recovery period in a nonsurgical manner. In the meantime X with Dr. X was advised. X X was X. X online psychiatric assessment continued to show X.

An MRI of the cervical spine dated X, revealed X. Discogenic changes were present with X as described at each individual level as follows: At the X, X, and X levels, X. The X were patent.

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 submitted documentation, the request is not warranted. The Official Disability Guidelines state that X. The guidelines further

required that the X be clinically appropriate as an initial procedure, that fewer than X. In this case, the injured worker was diagnosed with cervical spine strain. They presented with X. Physical examination demonstrated X. Imaging studies, including MRI and x-ray, revealed X. Given the absence of objective radiculopathy, lack of neurologic deficits, and no clear clinical-imaging correlation, the request for X is not medically necessary and appropriate, as guideline criteria require documented X. Therefore, the prospective request for X is non-certified."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "Upon review of the submitted records, it appears that the prior non-certification was appropriate. The referenced guidelines, which is the Official Disability Guidelines, stated that X. The guideline further stated that the X. In this case, the clinical information did not demonstrate X. Imaging did X. Functional impairment affecting activities of daily living or work activities was not documented beyond general pain complaints, and work status remained undisclosed. Although the injured worker underwent X. The request also included X, which the guidelines did not support for this procedure. As the request for the X is non certified, the associated request for X is likewise not medically necessary. As such, proceeding with this request is not medically necessary at this time. Therefore, the prospective appeal request for X is non-certified."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Based on the clinical information provided, there is insufficient information to support a change in determination, and the previous non-certifications are upheld. The Official Disability Guidelines note that X. The guidelines further required that the X. This patient's physical examination notes X bilateral deep tendon reflexes. The provider states in summary that there is a decreased pinprick in the X distribution; however, this is not noted in any of the physical examinations provided. There is X on MRI. There are no exceptional factors to support the use of X outside guidelines. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. The request for X is not recommended as medically necessary and the previous 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