P-IRO Inc.

Notice of Independent Review Decision

Case Number: Date of Notice: 7/26/2019 10:57:22 AM CST

P-IRO Inc.
An Independent Review Organization
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INFORMATION PROVIDED TO THE IRO FOR REVIEW: • Clinical Record –X
• Preauthorization Request for Surgery –X
• Utilization Reviews –X
• Diagnostic Data Report –X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X was working on X X and when X, X heard a X. X was diagnosed with X of the X X post onset with X, X, and post-X. On X, X was evaluated by X, DO. X was more X post X injury with X. X was doing poorly. X was released to a trial of regular duty, but began having a lot of X. X was having all of the typical symptoms of a X. X had X pain and medial joint line tenderness. X X and X tests were positive. It was noted that X really had not had any significant progress; and in fact, after the trial of regular duty, X began having a lot more X. X was on modified duty at the time, and X activities of daily living status continued to be restricted. X had finished all X and was on X. On examination, active range of motion of the X was -X degrees. X testing was X. X examination revealed tenderness over the X of the X. X had a X with significant X. The X tests remained positive and reproduced X X pain. Dr. X documented that Mr. X had failed significant X, X, and X benefit, so X (Dr. X) thought it was time now to switch from X over to X care. An MRI of the X dated X showed X. Treatment to date included medications (X) and X (completed X visits with minimal to no benefit to pain and function). Per utilization review determination letter dated X, the request for X as an outpatient was denied. Rationale: “The Official Disability Guidelines, X chapter, supports a X procedure for individuals with corresponding X symptoms and failure to improve with at

least X months of X treatment. Although this patient has X pain and X and has had X and X, it has only been X since the date of injury. Continued X treatment may help improve symptoms. Accordingly, this request is not medically necessary at this time." A reconsideration review determination letter dated X indicated that the reconsideration request for X was denied. It was determined that there was a previous noncertification for the request which stated that the Official Disability Guidelines support a X procedure for individuals with corresponding X and failure to improve with at least X of X treatment. Understanding the date of injury, the enhanced imaging studies completed, and the clinical assessment presented, there was a reconsideration request for X. When examining the clinical records, there had been no new clinical information submitted for review to support the request .As noted in the prior non-certification for the request, the Official Disability Guidelines support a X for individuals with corresponding X and failure to improve with at least X months of X treatment as it had been just X since injury, while noting the ongoing symptoms and treatment provided, continued X treatment might help to improve symptoms. Therefore, the request was not certified.

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

The ODG recommends X when there has been a failure of X care including X in addition to X or X with at least two persons subjective clinical findings, at least two objective medical findings, and imaging findings of a X. The ODG recommends X for the treatment of X following the failure of X months of X treatment. The provided documentation indicates the injured worker had persistent X pain and X injury despite treatment with X and X visits of X. There are objective findings of X, X, a positive X test, and a positive X test. There are MRI findings of a X. There is no evidence of X on MRI. While previous reviewers recommended noncertification of the requested X due to a lack of X months of X treatment, the ODG only requires X months of X treatment for X the setting of X.

The clinical findings are consistent with an X. As such, it was noted there has been a failure X treatment including X, subjective X and X, more than two objective findings consistent with X, and confirmation of a X on MRI, the X is supported and medically necessary. As the MRI does not document X, X, or X are not medically necessary.
The request is partially X. The X is medically necessary and the X and X are not medically necessary.

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

☐ 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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

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☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

ODG, 2019: XX and XX--Meniscectomy or meniscal repair