

P-IRO Inc.

Notice of Independent Review Decision

P-IRO Inc.

An Independent Review Organization

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PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. The mechanism of injury was not available in the records. The diagnoses were X. On X, X presented to X, MD for a follow-up. The MRI was reviewed and revealed X. On examination, X was X degrees, X was X degrees, X was X degrees, X was X degrees and X was X degrees. The X was X. Dr. X stated X did not think X was a X. On X, X presented to X, MD with complaints of X. X initial injury was on X, X sustained an X. At that time, X pain worsened. X went to see Dr. X, got a X in X without relief. X also underwent surgery in X. X stated that the X said X was X. X then saw Dr. X because of continued pain and had X. X had an MRI done and an independent medical examination; X was told that X had a X. X complained of X. Mr. X had difficulty X. On examination of the X, well X. Range of motion showed X to X degrees, X was to X, and X was to X. X was very painful to examination. There was a X. The X and there were X along the X. X was X to X but pain with exam. The MRI was reviewed and revealed X. X had X. It was recommended that X undergo X. On X, Dr. X resubmitted for reconsideration of X. The assessment was X. Dr. X believed X could benefit from X. X stated X understood that X had some other X that were not directly related to this, but X. An MRI of the X revealed X. Treatment to date included medications (surgery in X, and X with no improvement and eventual discharge. Per a Notice of Adverse Determination dated X, the request for X was non-certified. Clinical Rationale: "The ODG supports X. The documentation provided indicates that the injured worker has X. The provider states that previous treatment included X. A physical examination documented X. There is a diagnosis of X. Based on the documentation provided, the medical necessity for the X cannot be established as it is unclear if there has been a X. As such, the request is recommended for noncertification." A Physician Adverse Determination dated X indicated that the

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request for X, was noncertified. Clinical Rationale: “In this case, the claimant X. The claimant had X and states the therapist said X was not improving and discharged X. The claimant then saw Dr. X and had X. MRI of the X performed on X revealed X. There are two different doctors with different recommendations. Dr. X office note of X states X does not think the claimant was a X. Claimant sought a second opinion with Dr. X on X and was recommended X. The claimant has a functional capacity exam scheduled for X. At this time, X is not necessarily pending review of functional capacity evaluation results.”

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

The claimant had been followed for X. The claimant’s last orthopedic assessments did not include any specific X. The overall benefit from further surgery over the risks is not clearly established in the records provided. Therefore, it is this reviewer’s medical assessment that medical necessity is not established, and the prior denials are 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
- 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

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- 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
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TMF SCREENING CRITERIA MANUAL