P-IRO Inc.

Notice of Independent Review Decision

Case Number: Date of Notice: 6/25/2019 9:25:02 PM CST

P-IRO Inc.
An Independent Review Organization
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INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X Job Analysis Form –X
• Chiropractic Therapy Notes –X
• Clinical Record –X
• Functional Capacity Evaluation –X
• Notice of Adverse Determination –X
• Appeal/Reconsideration of Adverse Determination –X
• Attorney Letter –X

PATIENT CLINICAL HISTORY [SUMMARY]: X is a X-year-old X who was injured on X. X was a X on a X X when a X of the X resulting in a X. X sustained injuries to the X. MRI of the X dated X revealed X extends into the X. X are patent. On X, X. X was seen by X, DC for pain in the X. X had ongoing X pain with mild X. On X, X. X was seen by Dr. X for a follow-up. X reported improvement in the X pain. X reported X. The X pain radiated mildly into the X. On examination, X revealed mild X in the X. Kemp's test was positive for X pain. Straight leg raise was positive at X degrees with X. In a Functional Capacity Evaluation dated X conducted by X, DC, X. X reported an overall pain as a X. X reported X pain and described the X pain as X pain. The X pain was X. There was reported X. The X pain was X pain. The X and X pain increased with X. Manual muscle tests of the X were done to monitor X. Manual muscle test of the X was done to monitor nerves in the X. X demonstrated restricted range of motion in the X. X demonstrated a strength deficit in the X X. Based on the results, the overall level of effort as deemed by the examiner was

reliable. The result of X. X's Functional Capacity Evaluation revealed that X was unable to safely and dependably return to the usual and customary duties of X X with X, per the job analysis provided by X. X and / or employer. Overall, X demonstrated the ability to safely and dependably perform at a X physical demand level, which failed to meet the minimum job requirement for the job. An undated MRI of the X without X involvement. Treatment to date included medications (X) and X. In an Adverse Determination dated X, X, MD documented that "After speaking with Dr. X, it was stated that the patient's X pain was resolved with X. MRI showed a X. The patient has been treated with a X. The plan is to try work hardening to get X back to work. The patient has had X and X. There is no X, so the patient has not had an X. There is no X pain, it was stated. The patient does home exercises. X pain was improved with X. The patient does not fully meet the criteria per ODG guidelines. The patient has not exhausted all conservative measures. The patient has had improvement of X complaints with previous X but has only participated in X. The patient had a course of X and would definitely benefit from further X trial in conjunction with a X program prior to a X Should the patient still not reach PDL of previous employment, then X may be considered. Therefore, this request for X is not medically necessary. X hours is denied, not medically necessary and out of ODG." In an Adverse Determination dated X, X, MD stated that "XX never been reported to have any XX issues during X clinical encounters and X PT. X FCE is fairly consistent and does not reflect exaggeration or submaximal efforts or any other XX issues. These facts are conflicting with the XX evaluation / conclusion and need for the two components of WH program i.e., physical and XX counseling. I recommend denial of the X as there is no clear indication for the XX component."

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 X There is

insufficient information to support a change in determination, and the previous non-certification is X. The patient is not currently taking any medications. There is no clear rationale provided as to why the patient's physical demand level is limited to X when the patient sustained X. There is no documentation of an attempt to return to work in any capacity. There is no pre-program XX XX evaluation submitted for review.
Therefore, medical necessity is not established in accordance with current evidence based guidelines and the decision is X.

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