P-IRO Inc.
An Independent Review Organization
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Notice of Independent Review Decision

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:

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]:
X is a X who was injured on X when X. The diagnosis was X. An office visit by X, MD, dated X was documented. X presented with a complaint of X after X injury on X, when X was X and X, and noticed X. X stated X saw Dr. X who X which did not help and an MRI of X was ordered and X was referred to Dr. X for further treatment. X described a X along the X of X with X, which X rated X. X stated X pain was X. X examination showed X. An MRI of X dated X showed X. X was concerning for X, the differential diagnoses included X. X was recommended, and also to consider follow-up MRI to document the X of this finding. X was noted. Treatment to date included X. Per a utilization review adverse determination letter X, the request for X was noncertified by X, MD. Rationale: “The ODG does not recommend X for X. In this case, the injured worker has been diagnosed with

X. There were no exceptional factors that would support the request for X despite the guideline recommendations. Furthermore, the documentation does not suggest that all conventional conservative measures have been exhausted to potentially warrant deviation from guidelines. In consideration of the ODG and available information, X is not medically necessary. The ODG supports X for a X. In this case, the injured worker has been diagnosed with X. Given the presence of this pathology X is medically necessary. However, as X was unable to reach the treating physician to discuss X, the request remains not certified at the time." Per a reconsideration review adverse determination letter dated X, the appeal request X was noncertified by X, MD with the following rationale. "Not recommended. There is inadequate objective clinical evidence to support the use of X is not medically necessary and is not certified.

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

The ODG does not support X noting that X. The ODG supports X. The documentation provided indicates that the worker complains of X. Treatment has included X. An examination documented X. An MRI documented X. The provider has requested X. Given that X are not supported, and there are no exceptional factors present the requested X is recommended for noncertification. Given the documented X a X.

As such, a partial certification is recommended with certification for X and noncertification for X as medical necessity is established.

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

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL