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 with date of injury X. The X of the injury were not available in the provided records. X was diagnosed with X. X was seen by X on X for X. X complained of X. X was rated X. X reported X. X had X on X. X reported X. Treatment modalities included X. X continued to demonstrate X. X demonstrated X. X had X, which was causing X. X had X. X was unable to X. X had X on X and the X would be on X. X had X, but X. X would X after X. X was able to X in X without X. X continued to have X when X. X continued to require X in order to continue X such as X and X. X underwent an X initial evaluation on X by an unknown provider. The involved X included X and the chief complaint included X. The functional limitations included X. X presented with X. X increased X. Symptoms were experienced X. X had been

noted with X, and X was X. X was reported, and there was X. Examination showed X. X was noted at X. X test at X improved with X. X tests were noted to be X. The X scale score was X. X was seen by X, MD on X for complaints of X. The X was X without X and X on X after X. X reported X. X symptoms were X and X continued to have X. X stated X. X had a history of X. X stated X. The X was noted to be X. Examination of the X revealed X. X was noted over X. The X showed X. The X was X due to X. X was noted to be X. X tests were noted to be X. X tests X were noted to be X. An MRI of X dated X showed X. There was X. Findings of X were noted with the X and X. No X were noted to suggest X. X was X, which had been X. An MRI X dated X identified: X. The study was taken from the office visit note of X, MD on X. Treatment to date included X. Per a Utilization Review Decision Letter dated X, the request for X was noncertified. A Utilization Review Rationale by X, MD indicated the rationale as follows: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Medical records submitted were limited for comparative evaluation of findings to objectively X. In addition, clarification is needed regarding X if X exceeded the guideline recommendation or not. Pending this information, the request is not supported." An Appeal Utilization Review Decision Letter dated X indicated the appeal for X was non-certified. A Utilization Review Rationale by X, MD documented the rationale as follows: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The current request for X already exceeds the guideline recommendation. Moreover, a comprehensive assessment of X should be presented."

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

The ODG support X for the X. The documentation provided indicates that the injured worker complains of X. Imaging has indicated X. An examination has documented X. The injured worker has X. There is a request for X. Based upon the documentation provided, the requested X would not be supported as it is unclear X were X, if there was objective improvement, there is no indication X, and the current request exceeds guidelines.

As such, X is not supported as 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

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL