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 who was injured on X. The injury was associated with X. X had X. The diagnoses were X.

X was seen by X, X on X for a follow-up of X. The pain was the result of an injury, which occurred on X, which was X. X reported X. The onset was associated with X. X presented with X. X stated X. Upon asking where, X pointed to the X. X latest notes on X from the visit on X stated X could not X. X stated X still had X. On examination of the X, the X was reduced to X. There was X.

X had a follow-up with X on X for a follow-up of X. The pain was rated X. X stated Dr. X had ordered X. Dr. X still had X. X pain continued to be rated X. With X. X had

pain rated X at about X. Examination of the X. The X was reduced to X.

A X was documented on X by X, X. X had immediate X. X had undergone X. X had undergone X. X had undergone X. X reported after the X. Posttreatment, X pain at best was rated X and at worst was rated X. The X score was X. The pain X. The pain was located in the X. X included X. X was X. The X score was X. Examination of the X. X was X. X catch test on the X. X test and X tests aggravated the symptoms on the X. X strength. It was increased than prior examination. X continued to complain of pain at X. The X.

Treatment to date included X.

A Peer Review Report was documented by X, MD on X. The request for X. The rationale was as follows: “the history and documentation do not objectively support the request for an X this time. The ODG recommend up to X. The injured worker has attended what should have been a X. The request for X.”

Per a utilization review adverse determination letter dated X by X, MD, the prospective request for X. Rationale: “the history and documentation do not objectively support the request for X. The ODG recommend up to X. The injured worker has attended X. The medical necessity of this X. The request for X.”

Per a Peer Review Report dated X by X, MD, the request for appeal X. The rationale was as follows: “in this case, the injured worker has X. X is indicated but X. Therefore, the request for X.”

Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X. Based on the reconsideration review, it had been determined that the requested medical treatment X. Therefore the original X. The rationale was as follows: “in this case, the injured worker has X. X is indicated but the X. Therefore, the request for X.”

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Official Disability Guidelines recommends up to X. In this circumstance, the X. The

provider has recommended X. While to X. As such, 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

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL