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

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

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:

☒ Overturned Disagree

☐ Partially Overturned Agree in part/Disagree in part

☐ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who was injured on X. No office visits or imaging were available in the provided medical records, only two utilization reviews. Per a utilization review adverse determination letter dated X, the request for X, was denied by X, DPM. Rationale: “According to ODG by MCG, X. Outcomes from X, when indicated, are highly variable and somewhat dependent on X. Initial use of X. X, but can break down with use, where a X. X are not recommended X... X: Conditionally recommended. X are not generally recommended to X. " Also, per ODG by MCG, X. X may require an X. X on the opposite foot as a model, then sliding over the foot." This claimant has been reported to have X. A request has been made for a X. Guidelines do support X. In this case, no clinical documentation was provided for review. The current clinical status of the claimant is unknown. The type of X or the necessity for such procedures was not documented. There were no extenuating circumstances to support the request. Therefore, the request for "X" is not medically necessary. “Per a reconsideration review adverse determination letter dated X, the appeal requests for X was noncertified by X, DPM. Rationale: “The appeal request for a X is not medically necessary. The claimant had X. The claimant should X. Therefore, the appeal requests for a X is not medically necessary.PT had work related injury on X and subsequently had X. Submitted documentation states that pt has X. X have become worn and are in need of replacement. The Official Disability Guidelines recommend X: “X” Such devices are also supported in the following peer reviewed scientific article: X. Therefore, medical necessity is established. X is medically necessary and certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL

BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

PT had work related injury on X and X. Submitted documentation states that pt has X. X have become worn and are in need of replacement. The Official Disability Guidelines recommend X: “X” Such devices are also supported in the following peer reviewed scientific article: X. X. X. Therefore, medical necessity is established. X is medically necessary and certified.

Overturned

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