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

Amendment X

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 who was injured on X. Per a utilization review adverse determination letter dated X by X, MD the request for Right X was denied as not medically necessary. Rationale: "The Official Disability Guidelines criteria for X. The claimant is diagnosis is tear of right X. On X, the claimant followed up for right X. The examination findings included X. The X-ray showed a X. The MRI findings included an anterior- superior right X. The medical record indicates that the MRI findings showed a X right X. In addition, the medical records do not indicate if NSAIDs were used as a conservative measure. As such, the request for Right X is non-certified." Per a reconsideration review adverse determination letter dated X by X, MD, the reconsideration request for Right X on date of service X was denied as not appropriate and medically necessary. Rationale: "Official Disability Guidelines recommends X. On X, the claimant with complaints of right X rated X which is made worse with internally X. Right X exam shows X. No conservative therapy as well as mechanical symptoms were noted. As such, the request for X Right X DOS: X is non-certified." A prior utilization review for the requested right X was deemed not medically necessary. There is no documented conservative treatment rendered. There have been no submitted medical records for this independent review decision which would overturn the previous adverse decisions. Right X on date of service X is not medically necessary and non certified

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

DECISION:

A prior utilization review for the requested right X was deemed not medically necessary. There is no documented conservative treatment rendered. There have been no submitted medical records for this independent review decision which would overturn the previous adverse decisions. Right X on date of service X is not medically necessary and non certified

Upheld

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