TDI | Texas Department of Insurance

LHL713 | 0523

Independent Review Organization (IRO)

Notice of Decision Template WC Physio Solutions LLC

7500 Brooktree Road STE 300
Wexford, PA 15090
Phone/Fax: (855) 323-3654
@physiosolutions.net

Notice of Independent Review Decision

IRO

Reviewer

Report X

IRO Case number: X X

Description of the services in dispute

X.

Description of the qualifications for each physician or 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:

■ Upheld

□

□ (Agr

ee)

Overturned

(Disagree)

Partially Overturned (Agree in part/Disagree in part)

Information provided to the IRO for review

X

Patient clinical history

The claimant is a X who sustained an injury on X. Prior to the date of injury, the claimant had a X. The claimant was involved in a motor vehicle accident on the date of the injury which caused lower back and right leg pain. The claimant was initially placed on X with reported relief. The claimant X. The claimant reported no relief with X. The claimant reported X. The X lumbar MRI report detailed the X. A X was noted at X. There was X noted at X. At X, there was X noted contributing to X. The X lumbar radiograph report noted X. The X measured X. The X evaluation noted X. The X psychological consult detailed X.

Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision

The proposed surgery at X and X was denied by utilization review as a pre-operative psychological consult was not completed.

In review of the clinical records, the claimant has continued to describe lower back and right leg pain despite X. The claimant did have X completed in X. However, the claimant did have a X. Radiographs did not detail any evidence of X. Review of the last clinical evaluation detailed X. Therefore, these findings would not support proceeding with the proposed request for X per ODG treatment guideline recommendations for the low back as imaging did not X. There would be no requirement for a X request is not indicated. Therefore, it is this reviewer's opinion that medical necessity for the X is not established, and the previous denials are upheld.

Description and source of the screening criteria or other clinical basis used to make the decision

☐ ACOEM - American College of Occupational and Environmental Medicine
☐ Um Knowledgebase
☐ AHRQ - Agency for Healthcare Research and 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
☐ Presley Reed, The Medical Disability Advisor
☐ Texas Guidelines for Chiropractic Quality
☐
☐

Assurance & Practice Parameters TMF

Screening Criteria Manual

Peer Reviewed Nationally Accepted Medical Literature (Provide A Description)

☐ Other Evidence Based, Scientifically Valid, Outcome Focused Guidelines (Provide A Description)