TDI | Texas Department of Insurance

LHL713 | 0523

Independent Review Organization (IRO) Notice of Decision Template WC

Physio Solutions LLC 7500 Brooktree Rd STE 300
Wexford, PA 15090

Notice of Independent Review Decision

X

IRO Reviewer Report X

IRO Case number: 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 (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether **medical necessity exists** for **each** of the health care services in dispute.

X.

Information provided to the IRO for review

X

Patient clinical history

X, date of X, is a X

X.

The X Encounter with X, X DC, noted X presented after a work injury to X lower back. X noted X lower back complaints have gradually worsened since the date of injury necessitating X need to seek additional medical treatment. All weight bearing activities of daily liviing and sitting activities remain severely limited due to severity of lower back pain rated X. Lumbar range of motion was noted to be decreased. Orthopedic testing is X. Lower extremity testing is X and there is decreased sensation on X.

The X Encounter with X, DC noted the claimant reports X. Symptoms gradually returned to X. Pain is rated an X. X expresses moderate frustration due to the duration of symptoms and lack of long term pain relief and limited weight bearing function. The x-rays showed no X. The exam noted the claimant is full weight bearing and that moderate tenderness and spasms were noted to X. Lumbar range of motion remains relatively unchanged with decreased flexion and extension. Orthopedic testing is X. Lower extremity testing is X.

The Preauthorization Request noted that X were requested.

The X noted the claimant has X.

The X Response to Denial Letter stated that Dr. X office visits on X and X noted the claimant sustained a lower back injury caused by X. The claimant has X. Dr. X noted X was having frustrations and therefore referred the claimant to the office for X. It was noted it was evident X has X. This request is medically necessary for X.

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

The claimant is a X. Psychological evaluations are conditionally recommended by ODG in order to X. Without a formal psychiatric evaluation of the claimant to X cannot be considered reasonable or medically necessary and the previous denials remain 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)