

P-IRO Inc.

Notice of Independent Review Decision

Case Number: X

Date of Notice: X

P-IRO Inc.

An Independent Review Organization

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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

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who was injured on X. X had a workplace injury. X was sitting in an X. The diagnosis was pain in thoracic spine (M54.6), other intervertebral disc degeneration of lumbar region (M51.36), intervertebral disc disorders with myelopathy of lumbar region (M51.06), radiculopathy of lumbar region (M54.16), low back pain, chronic pain syndrome (G89.4), post laminectomy syndrome (M96.1), spondylosis without myelopathy or radiculopathy of lumbosacral region (M47.817), other spondylosis of thoracic region (M47.894), and spondylosis without myelopathy or radiculopathy of thoracic region (M47.814).

On X, X, MD evaluated X for low back and right arm pain. X had a history of X. X had X by Dr. X in X, which was explained in X. X was X by Dr. X in X. X had X. X had been unable to get X. X complained of some numbness and tingling in the upper extremities bilaterally. An electromyography (EMG) showed X. X recently had a X. X intermittently X. X was on X, X, X, X, and X and was X. On examination, cervical spine had X. X had X. X had spasm in the muscles. X had a X. X had pain with cervical rotation which was limited to right. There was decreased X. There was X.

Per a letter dated X, X, MD documented that X had persistent right arm pain and low back pain which extended up to thoracic region and down both legs. X workplace injury was sustained on X. X had X. X was followed by X. X had X. Unfortunately, despite being motivated, X injury had resulted in a X.

On X, X, MD evaluated X for X. X reported that X had noticed around X pain relief from X from X. X had a noticeable improvement but stated that X mid back between X shoulder blades continued to be quite painful in which X reported having intermittent pain radiating to X chest. X was noted to be tender to palpation along the X. X was recommended to X. If there is a positive result, X

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would be recommended to proceed with having X. It was also of note that X was starting X. X had another X. X ongoing regimen provided at least X relief with an increase in activities of daily living such as self-care. X ongoing pain level was X, worst pain level with medications was X, pain level without medications was X and percentage of pain relief with medications was X. On examination, X had X. The thoracic spine examination revealed X. Lumbosacral spine examination revealed X. There was X. There was a X. There was X. There was X. There was pain with X.

Per a letter dated X, X, MD documented that X medically necessary for treatment of X back pain.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale for X: "Based on the medical records currently available for review, there is no new events or additional information noted. It is still unclear if the X is requested for X. X should also be tried first. The external guidelines indicate the amount, level and quality of the evidence are only moderate for the effectiveness of chair interventions in reducing workplace musculoskeletal symptoms. No extenuating factors identified to support the medical necessity of the request overriding the previous determination. Hence. the request is not medically established." Rationale for X: "Based on the medical records available for review. There is no documentation of X. As per guidelines, a X is recommended if the patient is homebound, but there is no evidence of such documentation. No extenuating factors identified to support the medical necessity of the request. Hence. the request is not medically established." Rationale for X: "Based on the medical records available for review. There is no documentation of X. There is no radiating leg pain, weakness, swelling, shortness of breath or difficulty with sleeping noted. No extenuating factors identified to support the medical necessity of the request. Hence, the request is not medically established."

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Per a utilization review adverse determination letter dated X by X, MD, the request for X; X was denied. Rationale for X: “Based on the medical records currently available for review, there are no new events or additional information noted. It is still unclear if the X is requested for X. X should also be tried first. The external guidelines indicate the amount, level and quality of the evidence are only moderate for the effectiveness of chair interventions in reducing workplace musculoskeletal symptoms. No extenuating factors identified to support the medical necessity of the request overriding the previous determination. Hence. the request for X is not certified. Rationale for X: “Based on the medical records available for review. There is no documentation of X. As per guidelines, the X is recommended if the patient is X. but there is no evidence of such documentation. There is also a previous denial of the similar request. No extenuating factors identified to support the medical necessity of the request. Hence. the request for X is not certified.” Rationale for X: “Based on the medical records available for review, there is no documentation of X. There is no radiating leg pain, weakness, swelling, shortness of breath or difficulty with sleeping noted. No extenuating factors identified to support the medical necessity of the request. Hence. the request for X is not certified.”

Thoroughly reviewed provided records including provider notes and peer reviews.

While the patient is reported to have continued intractable pain issues, X have not shown significant benefit in terms of pain relief. Certain products such as X. However, there is no documentation that the patient has such functional deficits to the point that such requested X is medically necessary. X; X; X are not medically necessary and non-certified.

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

Thoroughly reviewed provided records including provider notes and peer

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reviews.

While the patient is reported to have continued intractable pain issues, X have not shown significant benefit in terms of pain relief. Certain products such as X. However, there is no documentation that the patient has such functional deficits to the point that such requested X is medically necessary. X; X; X are 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:

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- TMF SCREENING CRITERIA MANUAL
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- MILLIMAN CARE GUIDELINES
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- INTERQUAL CRITERIA
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

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ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGEBASE