

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

IRO REVIEWER REPORT

Date: X;Amendment 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 who was injured on X. X stated X. The diagnosis was sprain of ligaments of lumbar spine, initial encounter (X); sprain of ligaments of cervical spine, subsequent encounter (X); and other sprain of unspecified shoulder joint, initial encounter (X).

On X, X was evaluated by X, MD, for the chief complaint of upper extremity pain, low back pain, neck pain, and headaches. X was able to stand, sit, and walk for more than X minutes. The pain level at the time was X. The pain level at its worst was X, and at its best was X. The pain in the left lower back was described as sharp, aching. The shoulder pain was described as tension in the shoulders. X stated medication helped some and stated there were no significant changes since the previous visit. Examination noted no significant changes since the previous office visit dated X, which X. The assessment was sprain of ligaments of lumbar spine, initial encounter (X); sprain of ligaments of cervical spine, subsequent encounter (X); and other sprain of unspecified shoulder joint, initial encounter (X). The plan was to appeal the denial of X.

An MRI of the lumbar spine dated X, demonstrated X. It was noted that X. There was X was noted. At X. The X. The X. There was X. An MRI of the left shoulder dated X, identified X. There was X. X was noted of the X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X, was denied by X, MD. Rationale for denial of X, "Per ODG by MCG Diagnostic X,

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(updated X), "Diagnostic X: X." MRI of the lumbar spine from X reveals at X. X. X. X. X. Within the documentation provided for review, the claimant has chronic lower back pain. The claimant has exam findings of X. The claimant had a X. Guidelines support a X. However, guidelines do not support the use of X. This request cannot be modified without agreement from the requesting physician. Therefore, the requested X is not certified." Rationale for denial of X: "Per ODG by MCG X (Last review/update date: X), "Recommended for short-term use only. Diagnosis of X; Pain interferes with functional activities (e.g., pain with elevation is significantly limiting work); Intended for short-term control of symptoms to resume conservative medical management; Generally performed without fluoroscopic or ultrasound guidance; Only X; A X is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response." Per ODG by MCG X (Last review/update date: X), "X is NOT recommended for any of the following (3): X (4)." X. X. Mild X. X. Within the documentation provided for review, the claimant has chronic left shoulder pain. The claimant has exam findings of decreased X. The claimant had a previous X. However, guidelines do not support the use of X. This request cannot be modified without agreement from the requesting physician. Therefore, the requested X is not certified."

Per a reconsideration review adverse determination letter dated X, the appeal request for X, was denied by X, MD. Rationale for denial of X: "On X, the claimant presented to X, MD, for a follow-up evaluation. The claimant reported ongoing pain in both the upper and lower extremities, as well as persistent headaches. Pain levels were rated at X at best and X at worst. No significant changes were noted since the last visit. The prior examination had documented a X improvement in X. According to ODG by MCG guidelines, a X may be indicated when a X is performed; X are necessary to confirm X. This is appropriate if documentation indicates that the X. However, the guidelines do not recommend the use of X. The request for X was non-certified by X, MD. The denial was based on the fact that the claimant demonstrated X examination, consistent with X. The

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claimant had previously undergone a X. While guidelines support the use of a X. This request cannot be modified without agreement from the requesting physician. In this case, the provider has not submitted any compelling information or clinical findings to justify deviating from guideline recommendations. As such, the prior determination remains unchanged. Therefore, the request is recommended non-certified.” Rationale for denial of X: “According to ODG by MCG guidelines, X is recommended for short-term use only. Indications include a diagnosis of X. The pain should interfere with functional activities (e.g., limiting overhead work). The X is intended for short-term symptom control to allow resumption of conservative care. These X. Only X should be scheduled initially; X are not recommended. A X may be considered X. If the X results in complete resolution or no benefit at all, X are not recommended. However, ODG by MCG guidelines do not specifically address X. Literature was referenced and notes that the number and variety of procedures performed outside of the operating room continue to increase, with sedation frequently administered by non-anesthesiologists. Establishing a dedicated quality assurance system to monitor events associated with X. On X, the request for an X was non-certified by X, MD. The denial was based on the fact that the claimant had a X. In this case, a letter of appeal was not provided for review. The provider has not provided any new clinical findings or compelling information to support overturning the prior non-certification. Generally, the use of X. Additionally, there is a request for a X which was non-certified. The request cannot be modified without agreement from the requesting physician. Therefore, the request is recommended non-certified.”

Based on the clinical information provided, the request for X is recommended as medically necessary and the previous denials are overturned. The submitted clinical records indicate that the X. The patient was able to sit longer, stand longer, walk longer, sleep better and decrease pain medication. The patient reported X. The claimant received X due to the patient’s anxiety level. Guidelines support a X. Guidelines support a X. Given the additional clinical data, there is sufficient information to support a change in determination, and the request is

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overturned. X

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

Based on the clinical information provided, the request for X is recommended as medically necessary and the previous denials are overturned. The submitted clinical records indicate that the X. The patient was able to sit longer, stand longer, walk longer, sleep better and decrease pain medication. The patient reported X. The claimant received X. Guidelines support a X. Guidelines support a X. Given the additional clinical data, there is sufficient information to support a change in determination, and the request is overturned. 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:

- 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

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- 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
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE