# Peer Review

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|---|---|---|---|---|---|
| **Name** | | **SSN** | | **DOB** | |
| **Account Name** | | **Account #** | | **Incurred Date** | 03/08/1995 |
| **Claim Manager** | | **Incident #** | | **Claim Eff Dt-Status** | 05/01/2006 - Closed |

## ASO Only

**Customer Approved** | **Date**

**First Name** | **Last Name**

## Peer Review

**Requested Provider Specialty** * Orthopedist

**Rationale** * Conflicting Medical Information | **Specify Other**

**Vendor Referred Date** * 12/27/2006 | **Vendor Acknowledgement Date** * 12/28/2006

**Claimant Notification Date** * 12/27/2006

**Special Instructions**

## Peer Review Provider

**Provider Specialty** * Orthopedic Surgeon

**First Name** * | **Last Name** *

**City** * | **State / Province** * | **Zip Code** *

**Phone Number** | **Ext.**

**Fax Number**

**Report Received Date** * 01/11/2007

**Outcome** * Supports Functionality

**Complete Vendor QA Form**

## Vendor Quality Assurance

**Customer Service**

1. The ease in using this vendor service is rated as (on a scale of 1 to 5) * — 3
   Where 1 = Very Difficult and 5 = Very Easy

**Impact**

2. Impact/usefulness of the Vendor Service (on a scale of 1 to 5) * — 3
   Where 1 = No Impact and 5 = Strong Impact

**Professionalism**

3. Professional Delivery and Quality of Vendor Service (on a scale of 1 to 5) * — 3
   Where 1 = Least Professional and 5 = Most Professional

**Follow-up Required**

4. Was an Addendum Needed? * — No
   Reason for Addendum

**Vendor Alert Form**

5. Was a Vendor Alert Form submitted on this referral? * — No

**Expenses**

6. Were vendor fees within contracted fee schedule? * — Yes
   Cost * — $ 0.00

If No, provide rationale for additional costs

**Comments**

12-27-06 ANCM was on vacation and referral was sent by TL. Medical copied and delivered to vendor.

12-29-06 ANCM received Acknowledgement letter confirming Ortho/PR referral with completion by 1-12-07. ANCM will f/u with vendor by 1-13-07 if no report received.

1-11-07 ANCM received Ortho/PR report back from completed by orthopedic specialist, who found that the provided medical records are sufficient to support R/L that would prevent sedentary activity during the time period in question. Reviewer notes that cx is able to sit at a desk but would require frequent position changes with changing position every 10 to 15 minutes, is unable to do any standing, climbing, balancing, stooping, kneeling, crawling, or crouching and would be able to frequently lift or carry up to 10 pounds but would not be able to lift or carry anything for any distance more than approximately 2 feet but because of cx's ongoing use of OxyContin he would be unable to work. Please see report for details. Report returned. to TL.

**Last Changed User** **Last Changed Date** 01/11/2007 03:41 PM

**Status:** Completed **Assigned To:** **Created:** 01/11/2007 03:41 PM