P-IRO Inc.

Notice of Independent Review Decision

Case Number: Date of Notice: 8/16/2019 8:27:41 AM CST

P-IRO Inc.
An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 779-3287
Fax: (888) 350-0169
Email: manager@p-iro.com

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • Clinical Records –X
• Letters –X
• Utilization Reviews –X
• Diagnostic Data Reports –X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X while carrying a X pain. X was diagnosed with X. On X, X was evaluated by X, MD. X was injured while X. X was X pain. X had been complaining of severe pain ever since then in X. The pain was X and not improved by anything. X was taking different X and had X without any improvement. X was off work at the time. The examination showed X. X also had X. X also had X. X was unable to place X. X was able to abduct X X with the pain. On X, X condition remained unchanged. On X, X continued to have quite X. X had pain in the X area. An MRI of the X dated X revealed a X noted. The central X. A X was noted at X. Treatment to date consisted of medications (X) and X (without improvement). Per utilization review determination letter dated X, the request for X was denied. It was determined that a medical document dated X indicated that there was a documented diagnosis of a X. A medical document dated X indicated that a prior X MRI revealed findings consistent with the presence of a X level. A medical document dated X indicated that there was a normal X. A medical document dated X indicated that there was full range of motion in the X. At the time, for the described medical situation, the above-noted reference would not support a medical necessity for the specific request as submitted. Specifics were not provided to indicate whether there had been a

significant attempt at treatment in the form of physical therapy services, and specifics were not provided with regard to what type of prescription medications had been provided with respect to management of the described medical situation. Consequently, for the described medical situation, the above noted reference would not support a medical necessity. A utilization review determination letter dated X indicated that the reconsideration request was non-certified. Rationale: "Regarding the requested X, the patient presents with continued pain. However, there was no detailed documentation regarding the patient's previously trialed conservative treatment modalities. In addition, X are not recommended by evidence-based guidelines. There are no extenuating factors to support the use outside of guideline recommendations. Therefore, the request for X
X is non-certified."

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

The Official Disability Guidelines discusses X. X are considered "not recommended" in the X region. For this reason, the current request is not medically necessary. Moreover, as noted in a prior review, this patient appears to have multiple other competing diagnoses including a X. Additionally, there remains limited detail regarding the nature of the patient's prior treatment before considering invasive pain management.
For each of these reasons, alone and combined, the current request is not medically necessary and should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

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☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines and Treatment Guidelines--Facet joint medial branch therapeutic injections (blocks)