

**P-IRO Inc.**  
**An Independent Review Organization**  
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**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:

X

**PATIENT CLINICAL HISTORY [SUMMARY]:**

X who was injured on X. The diagnosis was X. Treatment to date included X. Per an Adverse Determination Notice dated X, the request for X was non-authorized. Rationale: "Based on review of the medical records provided, the proposed treatment X is not appropriate or medically necessary for this diagnosis and clinical findings. The claimant has X. Per X, there is X. The X. This condition may be X; however, per ODG guidelines, X are not recommended X. Therefore, the proposed treatment consisting of X is not appropriate or medically necessary for this diagnosis and clinical findings." X, an Adverse Determination after X was documented, indicating that the request for X was not medically necessary. Rationale: "The proposed treatment consisting of X is not appropriate and / or medically necessary for this diagnosis and clinical findings. Though the claimant has a X is not recommended per the ODG guidelines. Per the ODG Guidelines, "X is not recommended higher than the X." As such, the request for X is not medically necessary at this time."

**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 not recommended as medically necessary, and the previous denials are upheld. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The Official Disability Guidelines note that X are not recommended higher than the X. There is X submitted for review. There are X for review. there is X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & 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
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TMF SCREENING CRITERIA MANUAL