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. X was injured when X was X. The diagnosis was X. On X. X results X. X the X based on the X. X was X. It should be noted that X as a X was X. X to X. X were evaluated and X and X. X indicated X an X. X the X. X were X on a X. The X should X. On X and X. On the X which was within the X. On the X, which was X. X was X in which X. On the, X scored X. The provider requested that X. Treatment to date included X. Per a utilization review dated X and Peer Review Report dated X, the request for X was not medically necessary. Rationale: "The ODG does not support X. Within the medical information available for review, there is documentation of a X. Additionally, the X. However, there is X. Therefore, the request for X is not medically necessary." Per a utilization review dated X and a Peer Review Report dated X, the appeal request for X was not medically necessary. Rationale: "The injured worker has X. The provider is requesting a X. The injured worker X. Evidence-based guidelines do not support X. As such, this

request is not medically necessary."

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. Per a utilization review dated X and Peer Review Report dated X, the request for X was not medically necessary. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records indicate that the patient X. The Official Disability Guidelines do not support X. Additionally, the patient's date of X. The length of 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