**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:** Pain Medicine

**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 injured X. The diagnosis was X. Per an office visit with Dr. X was able to get X. Unfortunately, X continued to be X. X had pain with X. In the X. X was requiring X. X had X. While X it X. Consistent with the ODG guideline, X was X. X pain was X. X is X. X specifically told X would X. If X did X. X and improve X. As a result, we are going to resubmit tor the X. X is X. X was X. There has been X. X and X as X. we will arrange for X, pending X. Any further delays will lead to more X. A X was X. The treatment to date included X. Per a utilization review dated X, the request for X was denied. Rationale: “Regarding X, ODG notes that this treatment is not generally recommended. However, if used, In the X should only be X. X are not a stand-alone treatment. Documental X indicates the claimant previously had X. Benefit is not objectively described or detailed such as X. It is not clear the claimant is X is not supported as a stand-alone treatment. Based on

information available, X. Recommend non-certification." On X, the appeal for X was non-certified. Rationale: "Based on the documentation provided and per the ODG, the requested X is not considered medically necessary at this time. Although the X. Additionally, there was no documentation of X. The benefits were not X. Additionally, X are not recommended as a X and there was no documentation of X. As such, the request is not considered medically necessary in this case. X am in agreement with the prior denial since not enough information has been provided regarding objective functional benefit from the prior 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 not recommended as medically necessary, and the previous denials are upheld. Per a utilization review dated X, the request for X was denied. Rationale: "Regarding X, ODG notes that this treatment is not generally recommended. However, if used, In the X should only be X. X are not a X. Documentation indicates the claimant previously had X. Benefit is X. It is not clear the claimant is involved in a X. Based on information available, X. Recommend non-certification." On X was non-certified. Rationale: "Based on the documentation provided and per the ODG, the requested X is not considered medically necessary at this time. Although the X. Additionally, there was no documentation of how X. The benefits were X. X are not recommended as a X. As such, the request is not considered medically necessary in this case. I am in agreement with the prior denial since not enough information has been provided regarding X. There is insufficient information to X are upheld. While there are subjective reports of X. The submitted clinical records indicate that the patient stated X. There is no documentation of any X. It is unclear when X.

There are no procedure reports submitted for review. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. The request is upheld.

**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