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: @p-iro.com

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:

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who was injured on X when X. X was X. The diagnosis was X. On X, X, MD evaluated X who presented for a X. X scheduled for a X on X for X. The pain was located at X, was X and X. Examination noted X. X used X for X. Examination of X showed X due to X. X and X was noted. X examination showed X. X were X. Per a X, Dr. X placed X as of X through X. Treatment to date X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Per evidence-based guidelines, X is recommended as an option for the treatment of X, although there are X and more X. It is especially recommended for patients with X. X is recommended X if progress is being made. In cases of X or X, up to X if progress is being made. Studies show that X should be sufficient to provide X, but X indices do not change as markedly within X as do X. In this case, the patient was recommended at this time by Dr. X to continue X due to the X. Per the treatment plan / recommendations, the provider would like to request for X with X as a treatment modality for X. The treatment goals were to X. X had been

certified for X. A request for X was made. Given that the patient had X; however, the X from X were not established. The prior treatment notes should be submitted for review to validate X and support X. Clarification is needed with regards to the request and how it affects the patient???s clinical outcomes. In an appeal letter dated X, X documented: X. First, we were unable to complete the peer review with physician advisor on time to discuss further our rationale for our requested services, so please accept this appeal letter for reconsideration. At the time our Treatment Progress Report of X was submitted, as noted by treating physician, X, MD, X medical condition X. A recent Xof X was done, and it showed X. X has X, and there has been mention of X. Dr. X has reported X, has discussed this to be the next appropriate medical plan of care. Our Treatment Progress Report did provide a clinical summary (please refer to page 3 of our report submitted for review) further justifying why X. Over the X, X has been X with X and X. In the beginning of X, X continued to X. X continues to X. X as well as X to X. X has consistently X, X likes to X. X expressed X. X stated that X. X will X and then X. With the above mentioned, this treatment team recommends that X. Literature supports that X. X does meet medical necessity to X. Next, with medical justification provided above, X continues to X. X current medical diagnoses are X. As per review of medical records, X has X as a result of X; Dr. X has documented X. Since being referred to our practice in X of this year X which was for X, once X; X was advised for X. Our office submitted for services X. With respect to above medical information documented and X; we are making every effort to establish ongoing medical necessity to X. References by Official Disability Guidelines (ODG)- X. Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X. Rationale: “Given the presented clinical findings of the patient, the request may be medically necessary. However, the totality of X as well as X, X, and X were not completely established. A most recent or an updated office visit with X should be submitted to determine the current status of the patient. Clarification is needed for the request at this time and how it X. X were not identified. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified.”

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

The request for X falls within the ODG X Guidelines which states that if progress is being made, X is appropriate. Additionally, in the case of X, up to X is appropriate, if progress is being made. X are that X so any X can be identified. In the case of X, X of X with X on the X, the X, and the X. Scores on the X remained unchanged. Additionally, X score of the X. As a result, a X was provided that included X.
It is particularly important to note that X case is X. Given the documentation available, the requested service(s) is considered medically necessary.

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