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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who sustained a X when X was X. The X. When this happened X. The diagnosis was X. Per a Report of X, DC certified that X. The X was X. On X, MD evaluated X. X reported a X. X underwent X. X and X. The X at X. Examination noted X. X of the X. Dr. X opined that X. In Dr. X opinion, X would X. Dr. X opined that X. The mechanism of injury and the description of the incident were X. It was more likely X. An X and X. This was to be X. X were noted of the X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “The ODG recommends X. The ODG recommends X and X. The ODG recommends X. The ODG supports the use of a X.

The provided documentation indicates the X. There are X. A recent X. As there is X is not supported. As it is X is not supported. Based on the available information and ODG recommendations, X are not medically necessary. The ODG supports X. However, as X is not medically necessary, X is not medically necessary. The ODG supports the use of a X. However, as X is not medically necessary, X is not medically necessary." Per a utilization review adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: X. As the requested X is not supported, the associated request is not supported. Therefore, the request is non-certified. As the requested X is not supported, the associated request is not supported. Therefore, the request is non-certified. Per the Official Disability Guidelines X. Based on the provided documentation, the claimant reported X. Upon examination of the X it was revealed that the X. X of the X. The claimant was treated with X. However, there is X. Guideline criteria has X. Therefore, medical necessity has not been established and non-certification is recommended. As the requested X is not supported, the associated request is not supported. Therefore, the request is non-certified."

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

The claimant had been followed for X. There was an X to the X. The available records did not document X. The current MRI X.

Therefore, it is this reviewer's opinion that medical necessity is not established for the requested X.

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