P-IRO Inc.
An Independent Review Organization
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Notice of Independent Review Decision

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 is a X who sustained an injury on X while X. On this date, X reportedly X. X was seen by X on X for X. X complained of X. The X was rated at X. The symptoms were X by X and X. They were X by X. Examination of the X from X. X was noted with X. X of the X showed X or X. An X of the X dated X revealed X. Treatment to date included X. Per a Utilization Review decision letter dated X, the request for X was denied by X. Rationale: "The records submitted for review would not support the requested X as reasonable or necessary. The claimant had reported X. The current X noted X, but X and X. The available X did not quantify the extent of the reported X. The records did not detail X to include X or X. Given these issues which do not meet guideline recommendations, X can not recommend certification for this request. X: Due to the non-certification of the X with X this request is not medically necessary and recommended noncertified." Per an Adverse Determination letter dated X, the prior denial of X was upheld by X, whereas request of X was approved. Rationale for denial of X: "Regarding X, ODG states that X is not recommended following X. X may be appropriate in patients with X (other than X). In this case, the claimant is approved for X. Guidelines do not support use of X. Thus, the medical necessity of X is not established. Denial is recommended."

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

The ODG does not recommend X following X. The documentation provided indicates that the X has been authorized for X. The provider has recommended X following X. X treatment included X. When noting X are not supported following X and when the provided documentation indicates that the X has been utilizing X, the purchase of X for X would not be supported.

As such, X is not supported as 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