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

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 was injured on X when X. The diagnosis was X. X had a consultation with X, MD on X for follow up of X. X had X. At the time, X still felt the X. X showed what could be X. X had tried X and X with little help. X rated X as X which was X with trying activities. X described X somewhat in the X. At the time, X was on X, X, X and X. X also did X. Examination findings showed X. There X was X on X and X. X was done with X to X noted. The X were reported with X. There was X over the X. There was X over the X. The X was X. The X were X, except X. The assessment included X. X and / or referral to X was discussed. X agreed to proceed with the X. An X of X dated X revealed X and X at X and X without evidence of X or X. There were X also and X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X at X was noncertified. The rationale given was as follows, “This is a request for X. ODG guidelines note,

Conditionally recommended as a short-term treatment for X with corroborative findings of X. This treatment should be administered in conjunction with active rehabilitation efforts, including X and/or X. Not recommended for treatment of X resulting in X unless there are X findings on examination. X are not recommended as a treatment for X or for X. X at X are not recommended. See specific criteria for use below. The patient has X and X and X has X. A X was done in the past with X noted for about X. However, this request exceeds guideline recommendations as there was no documentation of X in the X that was provided for review. Furthermore, despite X, X were not documented. Based on the records reviewed, the medical necessity for this request has not been established, and therefore, the request is denied." Per a reconsideration review adverse determination letter dated X by X, MD, the prior denial of the request for X was upheld. The rationale, "Regarding X, ODG notes that X are not routinely recommended unless there is evidence of X after a symptom-free period. Evidence indicates that X should be restricted to patients with X for less than X. Therefore, the following criteria should be considered: (i) X should require documentation that previous X produced a minimum of X and X for at least X. (ii). X is better supported with documentation of X after the previous procedure. Documentation reflects the claimant recently underwent X with X for about X. Request is now for X at another level X. X report was reviewed. There is no X or X reflected at either X. There is X noted at X. There is no clear indication the claimant has a condition for which this treatment is supported. Prior X was at another X and provided X for the X minimum. ODG notes that there is no evidence that X alone offer any meaningful long-term functional benefit. There are no X described from this prior X. Prior request was denied due to similar rationale. Recommendation is to uphold the prior non-certification."

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. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient's physical examination fails to establish the presence of X. X is X. X shows an X at both X and X. X is X throughout. X are X and X. The submitted X is of exceedingly X and is difficult to

interpret.
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