IRO Express Inc.

Notice of Independent Review Decision

Case Number: Date of Notice: 7/22/2019 3:31:06 PM CST

IRO Express Inc.
An Independent Review Organization
2131 N. Collins, #433409
Arlington, TX 76011
Phone: (682) 238-4976
Fax: (888) 519-5107
Email: reed@iroexpress.com

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • Clinical Records –X
• Physical Therapy Notes –X
• Adverse Determination Letters –X
• Diagnostic Report –X

PATIENT CLINICAL HISTORY [SUMMARY]: X who sustained an injury on X. X slipped on a XX XX and fell on X XX XX and XX. X was diagnosed with X pain; X, X; other X, X; X, X; and X pain. X was evaluated by X, DO on X for X pain, X, and to discuss X. The pain was located at the X, referred to the X. The pain was rated at X. It remained unchanged. On examination of the X, there was X. The active range of motion (AROM) in X was full to X degrees with moderate X pain X was full and X to X degrees. There was X at the X. X test produced pain in the X area. Sensory examination for a light touch in the X on the X showed X in an X distribution. Deep tendon reflexes on the X were X and on the X was X. X was positive on the X producing X pain. The plan was to proceed with X. An MRI of the X dated X revealed X, minimally increased from the previous study dated X. The treatment to date included medications {X (helpful)} and X. Per a Utilization Review Decision letter and peer review dated X, the request for X was denied by X, MD. Rationale: "Per evidenced-based guidelines, X is recommended as a possible option for short-term treatment of X pain with use in X with X efforts for patients with documented objective findings on examination X by imaging studies or electrodiagnostic testing and after being initially unresponsive to X treatment. In this case, the patient complained of X pain referred to the entire X. Review of systems was positive for X. The examination showed X distribution, X, and X raise

(X) was positive on the X pain. MRI of the X dated X showed X level. A X had been recommended; however, there was limited objective evidence in the medicals submitted that the patient was initially unresponsive to X treatments such as X, X, X, X, and X XX prior to considering the requested X." Per a Reconsideration Adverse Determination letter dated X, the prior denial was X by X, MD. Rationale: "Per evidenced-based guidelines, X is recommended as a possible option for short-term treatment of X pain with use in X with X efforts for patients with documented objective findings on examination corroborated by imaging studies or electrodiagnostic testing and after being initially unresponsive to X treatment. In this case, the patient complained of X pain referred to the entire X. Review of systems was positive for X. The examination showed X pain. A X had been recommended; however, there was limited objective evidence and recent imaging studies in the medicals submitted that the patient was initially unresponsive to X treatments such as X prior to considering the requested X."

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

Official Disability Guidelines discusses indications for X. An X may be indicated in situations where a patient has symptoms, exam findings, and electrodiagnostic or imaging studies which correlate to confirm a X at a particular location. The medical records in this case do not document such a clinical scenario. In particular, MRI imaging specifically notes the lack of X in the X and there is no electrodiagnostic study to alternatively confirm a X. The records do not provide an alternate rationale to confirm X.

Given the documentation available, the requested service(s) is considered not medically necessary and the decision is X.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

IRO Express Inc.

Notice of Independent Review Decision

Case Number: Date of Notice: 7/22/2019 3:31:06 PM CST

☐ 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

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL