IRO Express Inc.

Notice of Independent Review Decision

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PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X was injured when X. The diagnosis was X. X presented to X, MD on X for a follow-up. Per note, X continued to have pain in X. X did get temporary relief after X. X had pain on the X with an associated X in that region. X had significant difficulty after prolonged activities. On examination of the X, there was a X. There was pain with direct pressure. X-rays were interpreted as normal. The assessment was X. Dr. X discussed with X regarding X and the fact that they may recur. They also discussed X and the risks and benefits of X. After a thorough discussion, X wished to proceed with X. An electrodiagnostic study dated X was performed for radiating pain into the X. There was electrodiagnostic evidence of X. The reinnervating potentials observed in the X. Mild, X. There was no electrodiagnostic evidence of X. Treatment to date consisted of X. In a peer review completed by X, DO on X and a utilization review dated X, the recommendation and rationale were: "I am recommending non-certifying the request for X: As per ODG criteria, X is recommended as indicated requiring symptoms (X). X: Activity modification 1 month, night X1 month, X. It is noted on X, an EMG / NCS of the X was performed. The exam revealed evidence of mild-moderate, X. On X, injured worker presented to Dr. X with complaints of X pain with X. The injured worker has noted temporary relief from X. The injured worker has pain in the X. On examination, there was X. Although there was a positive X test and the X. As such, ODG criteria has not been met and medical necessity cannot be established. Therefore, the request is recommended certified." On X, X, MD performed a peer review and rendered the following opinions: "Within the associated medical file, there is documentation of X. X noted temporary relief from X. There is increased X. Exam noted decreased X. There was a positive X. The

X EMG shows mild to moderate, X. The reinnervating potentials observed in the X is less likely and there is no electrodiagnostic evidence of X, focal X. However, there still remains no clear documentation of X pain, X. Based on the currently available information, the medical necessity for this procedure has not been established. Therefore, I am recommending non-certifying the request for X" A utilization review dated X reflected the opinions provided by Dr. X in X peer review on X.

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

The ODG recommends X when the following criteria are met: two of the following: X. The ODG recommends X when there is X related pain. The provided documentation indicates there is X. The injection provided temporary symptom relief which is diagnostic for X. There are physical examination findings of a X, decreased X. Electrodiagnostic studies have confirmed mild to moderate X. When noting there is a X, requested CPT code X is supported. While not all criteria are met for X, X, objective evidence of decreased X is necessary.

Based on the available information, X are medically necessary. Recommendation is for overturning the previous denials.

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

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES