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

Date: 1/2/2019 4:15:14 PM CST

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XXXX.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Orthopaedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☐ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX. Per the Statement of Medical Necessity by XXXX, XXXX was a very consistent user of XXXX XX XX XX XX XX. Evaluation of XXXX activity level indicated that XXXX required an XX XX XX to be used in activities where the XX XX did not provide the appropriate function. The XX. The XX. XX therapists with specialized training and expertise in XX XX XX was also essential for XXXX long-term success. Per a request for authorization signed by XXXX, XXXX was an ongoing patient of XXXX. XXXX was XX with a XXXX XX XX passive XX approximately XX months prior. When seen recently in the office, it was noted XXXX had successfully XX XXXX XX XX for the prior XX months. While this XX provided opposition by allowing XXXX to post XXXX XX against objects in XX to XX XX, XXXX did find XXXX still had XX when XX daily living activities. During the appointment, it was determined that XXXX would benefit from the provision of an XX. The proposed XX was the only XX for the XX level XX. XX. XX. The prescribed XX would provide XX. Use of the XX. Treatment to date included XX surgeries, one on XXXX, and XX and XX XX in XXXX. Per a utilization review determination letter dated XXXX, the request for XXXX XX coordination was denied. Rationale: “The claimant sustained XX XX XX and has been XX a XX XX for the last XX months. Justification presented states, "XX." However, there are no subjective or objective exam findings provided for this review. Also, it is not that there won't continue to be limitations with activities of

daily living (ADLs). Discussed at length with a certified XX. The claimant is XXXX XX XX. XX on the XXXX. The claimant XX. Reviewed guidelines and rationale. XX is not XX. There is insufficient information provided to verify medical necessity. As presented, medical necessity is not established. Recommend non-certification." An appeal letter dated XXXX, reported the request would significantly reduce the likelihood of XX complications in the XX XX and XX. XXXX would reach a functional state within XX months of being XX XX a XX XX XX and upon receiving comprehensive therapeutic XX training. XXXX was highly motivated to XX in order to increase XXXX functional status in every aspect of XXXX life. XXXX's XX surgeon had recommended that XXXX be XX with the XX as indicated by the signed Statement of Medical Necessity. A utilization review determination letter by XXXX, indicated that the reconsideration request was denied/non-certified. It was determined that, according to guideline criteria, XXXX had an XX or XX XX at the XX or above (i.e., XX, etc). Per clinical, the XX were at the XX level and XX. Per guideline criteria, standard XX-XX XX XX could not be used or are insufficient to meet the functional needs of the patient in performing activities of daily living. Per clinical, there was no documentation, subjectively or objectively, of insufficient functions or type of activities of daily living that were unattainable with the XX XX. The clinical information provided did not support medical necessity, and the request was recommended as non-certified.

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

In review of the provided records, there was evidence of multiple XX. The appeal letter indicated that the claimant would benefit from the requested XX to XX XX XX in the XX XX and overall improve the claimant's function. The claimant was XX to use the XX and increase XXXX functional status.

Therefore, it is this reviewer's opinion that medical necessity is established and the denial is overturned.

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

XX