IRO Express Inc.

Notice of Independent Review Decision

Case Number: Date of Notice: 6/5/2019 1:21:50 PM CST

IRO Express Inc.

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: Medical Peer Review –X

- Clinical Records –X
- Notice of Disputed Issue and Refusal to Pay Benefits –X
- Peer Review Reports –X
- Utilization Review –X
- Diagnostic Data –X

PATIENT CLINICAL HISTORY [SUMMARY]: X. X X is a X-year-old X who was injured on X. X sustained injuries to X X, X X, and X X while working as a X for X X when X X through a XX in an X, X where X was hit between X lX, and believed X X X X X when X X. X was diagnosed with X. Per an office visit by X MD dated X, X. X presented for a follow-up visit for X X and Xl X pain, worse on the X. X reported pain, X. The pain scale was reported as X. The pain was X. X had X restriction with X activities, as well as X activities. X had Ax x examination showed X, X to pain, X and XX, X test on the X. XX dated X revealed a X creating moderate X with X type X consistent with X. There were X with a X measuring X creating moderate. Treatment to date included medications (X), X and X on X with 0% relief. A peer review was completed by X, MD on X. It was Dr. X opinion that the X was not medically necessary as repeat X are not supported due to lack of pain relief and improvement from the prior X. The medical necessity had not been established. Therefore, the request for X X-X was not medically necessary. On XX, XX completed a peer review and opined that the request for X was not medically necessary. Lacking an appropriate X or better response for X weeks as recommended by ODG prior to considering, X. X received 0% relief with the X the request for the X was not medically necessary. Therefore, the request for the XX X was not medically necessary.

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 at X is not recommended as medically necessary, and the previous denials are upheld. A peer review was completed by X, MD on X. It was Dr. X opinion that the X was not medically necessary as repeat X are not supported due to lack of pain relief and improvement from the prior X. The medical necessity had not been established. Therefore, the request for X at X was not medically necessary. On X, X, XX completed a peer review and opined that the request for X was not medically necessary. Lacking an appropriate X or better response for six to X weeks as recommended by ODG prior to considering, X. X received 0% relief with the X, the request for the X was not medically necessary. Therefore, the request for the X at X was not medically necessary. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient underwent prior X. Follow up note dated X indicates that the patient reports 0% relief. Pain level is X The Official Disability Guidelines require documentation of at least X pain relief for at least X weeks prior to repeat X. The Official Disability Guidelines require documentation of X on physical examination corroborated by imaging studies and/or X results. The patient's physical examination notes that X. Sensation is grossly intact. X are 2+ X.
Given the documentation available, the requested service(s) is considered not medically necessary in accordance with

current evidence based guidelines and the decision is upheld.

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

Epidural steroid injections (ESIs), therapeutic