IRO Express Inc.

Notice of Independent Review Decision

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PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X was working as a X. When X. The diagnoses were X. On X, X was seen in a follow-up evaluation by X, DO. X continued to suffer from X. On examination, X had X. Dr. X added that X also had X. X affect was worsening. The dose of X. The follow-up note on X documented X to have X. X had all X efforts, and X was now on a combination of X. Dr. X indicated that X showed X. The treatment plan included a X. An MRI of the X dated X was remarkable for: moderate X. Treatment to date included X. Per a Physician Advisor Report dated X, the request for X was non-certified. Rationale: “According to the Official Disability Guidelines, a X are the only recommended option; X are not recommended X is not recommended when administering a X. In this case, the patient had X. A recommendation was made for a X. The patient had imaging evidence of a X. However, guidelines do not recommend X. As such, the medical necessity of this request was not established for this patient. Based on the above documentation, the requested X is non-certified.” Per a Physician Advisor Report dated X, the request for X was non-certified. Rationale: "This request was previously denied given guidelines do not recommend X, and there were no examination findings of X. There remained no exceptional factors provided supporting a X beyond guideline recommendations. There were no examination findings of X. There were no exceptional factors provided supporting X beyond guideline recommendations. As such, the medical necessity of this request was not established for this patient. Given the X is not appropriate for this patient, the requested X is also not appropriate for this patient. Based on the above documentation, the requested X is non-certified."

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

As discussed in a prior physician review, X are recommended only in exceptional circumstances given significant risks of this procedure. The records do not document X suggestive of a X. Moreover, a rationale to support the additional risk of X is not apparent. Overall, similar concerns discussed at the time of a prior physician review have not been addressed at this time.

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

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