IRO Express Inc.

Notice of Independent Review Decision

IRO Express Inc.

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Amended Letter

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

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

REVIEW OUTCOME:

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

X

PATIENT CLINICAL HISTORY [SUMMARY]:
X is X who was injured while at work on X, when X. The diagnosis was X. X was seen for a follow-up of X by X on X. Recent MRI of the X results X. On examination, X was X for X. There was X for X and X. X was X. Dr. X was X with X. X had documented X as described above, which had been X to conservative care efforts. Dr. X believed X was a candidate for X. An MRI of X, showed X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the requested services were denied. Rationale: The documentation did not fulfill the ODG criteria for X. Except for demonstrated X, X examination was X. X were reported as X. X MRI showed X that did not correspond with X. On this basis, the physician's request for X was noncertified as well X were also noncertified. In a letter dated X, Dr. X documented that X was provided to X since conservative care options had been exhausted. X received X after X. Dr. X believed it X. On X, Dr. X amended the above letter. X made a correction to X previous note and wrote that X. X had previously recommended X since conservative care options had been exhausted; however, this was denied by the carrier. Dr. X believed it was reasonable to proceed with X. Per a reconsideration review adverse determination letter dated X, X, MD upheld the prior denial. Rationale: "The X indicates X. The ODG recommends X. The ODG does not recommend X. The ODG only recommends X. The provided documentation indicates there is X. There are X. The appeal letter indicates conservative care options have been exhausted, so X. Given the lack of clinical findings to corroborate X and lack of X, X is not supported. There is no evidence that X. There are no extenuating circumstances that would support X. Based on the available information and ODG recommendations, X are not certified."

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 is not recommended as medically necessary, and the previous denials are upheld. The Official Disability Guidelines note that X. The Official Disability Guidelines note that X. There is no documentation of X.

Therefore, medical necessity is not established in accordance with current evidence based guidelines.

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