IRO Express Inc.
An Independent Review Organization
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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 sustained an injury on X when X. The diagnoses included X. X was seen by X, on X. X complained of X. X also had symptoms that X. X had X. Examination of the X revealed X and X were noted. X was X in X. An X dated X showed X. Treatment to date included X. Per utilization review by X, on X, the requests for X were non-certified. Rationale: X with a history of X on X injured X. The patient is X. The patient has X. X MRI shows X. X has X. The proposed X is X. The current X has not been documented with X and the response to the X is not reported. There is no physical exam documentation of X to include X. Based on the information provided, the medical necessity of the request cannot be confirmed. Therefore, the requested X is not medically necessary." Per utilization review by X on X, the requests for X were non-certified. Rationale: "This X sustained an injury after X on X. The patient X. On X dated exam, the patient had X. Physical exam revealed X. Imaging revealed X. X treatment in the form of X has been X. However, X of X was not provided for review. The patient recently underwent X with no documentation of X. In addition, there are X findings supportive of the proposed procedure. Other causes of X have not been ruled out, especially considering the reported X. Successful peer discussion revealed the office does not have the prior X notes nor any recent X description of X. The peer also related that the patient X. It was discussed that specific results of X that had X have X. Medical necessity is not established. Therefore, the requested X is not medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The ODG supports X for treatment of X unless X. The ODG supports X for X after X. The documentation provided indicates that the X continues X which X. Symptoms X and X. An exam of the X documented X. An MRI the X documented X. Treatment has included X. The treating provider has requested X. Based on the documentation provided, X would not be supported as there is no documentation of X.
As such, the requested X are not medically necessary.

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Notice of Independent Review Decision

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