

**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:

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who sustained an injury on X when X. The diagnoses included X. X, MD examined X on X for evaluation of X. The X pain was rated X and it was X. X had X and X. X stated that X, X and X. X examination revealed X. X demonstrated X. X was seen by X, MD on X for follow-up following X. X reported X. X complained of X. X also had X. The pain was rated X. On examination, X had X. There was X. The X was X. Per a X note by X on X, X had X. X complained of X. The pain was rated X and X stated that X. X reported X. X would like to X. X was X. Per assessment, X continued to demonstrate X. An X of the X on X showed X. Treatment to date included X. Per peer review by X, and a utilization review letter dated X, the request for X was non-certified. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, the request for X is not recommended as medically necessary. There is no updated clinical information provided as the most recent office visit note submitted for review is from X. There is no documentation of X to support

evaluation. There is no X submitted for review. X spoke with Dr. X on X, and X agreed to fax clinical information regarding X. A fax was received but contained only a X from X. Without additional information, medical necessity is not established in accordance with current evidence-based guidelines.” Per peer review by X, MD and a reconsideration review letter dated X, the request for X was non-certified. Rationale: “Per evidence-based guidelines, X, X, and X. It should be X to determine whether X are indicated. X can be a X for X. The patient complained of X. However, was still no documentation of current X to support evaluation. There was still no X submitted for review. Moreover, the current clinical impression of X, X, or X were still not clearly specified in the documents presented to warrant the need for the requests. Furthermore, X of X were still not evident to support the request. Clarification is needed for the clear indication of the request and how it would X. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, the request is non-certified. There is no clear rationale for the requested X.”

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

The request for X is not recommended as medically necessary, and the previous denials are upheld. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. Office visit note dated X indicates X. On this date the patient was recommended for X. Note dated X indicates X. X dated X states, X. Review of systems on X notes that on review of systems X. X note dated X indicates that the X. X note dated X indicates that X. There is no clear rationale provided to support X given the patient’s clinical presentation.

There is no documentation of X to support the performance of X at this time. Recommend non-certification.

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