

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who X. X and the X. The diagnoses included X and X. A X on X was X. Following the X was X by Dr. X. It was documented that that X had X. Following evaluation, recommendations were made for X. Instructions were given for a X. X were X. On X, Dr. X of the X. On X, Dr. X performed: X. X was seen by X, NP on X for X. X of X and X. X was noted in the X, and X. X rated the pain X. The X were X. The X or X. X and X. X had a X. The X. X revealed X – X and X - X. X was X and X. X was X. X revealed X. X was X from X and X. A X was X. An X demonstrated X and X and X and X. There were X and X. There was X and X and X. There was X. Treatment to date included X and X

and X. Per a peer review by X MD on X, the request for X was non-certified. Rationale: "The requested X is not medically necessary. Per the ODG, X. This X is based on an X. X is X. In this case, the X and X and X. The documentation notes that the X, there is X. Therefore, the requested X is not medically necessary." Per a peer review by X, MD on X, the request for X was non-certified. Rationale: "The Official Disability Guidelines X. X may be X. The benefit from a X. X, a X is not medically necessary at the time. The request should be non-authorized. Thus, the requested X is not medically necessary. Per a peer review by X, MD on X, the request for X was non-certified. Rationale: "The X. There is a request for a X. The documentation X. The injured worker's X, this request is not medically necessary."

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

Given the current clinical data, the request for X is not recommended as medically necessary. There is X to X and the previous non-certifications are upheld. There is X at the requested level on the X. X notes X. The patient X. Office visit note dated X. There is X and 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