IRO Express Inc.
An Independent Review Organization
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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

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

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X with a date of X. X sustained an injury when X was X. The X got X from X. X was diagnosed with X. X was seen by X, MD on X and X. On X, X presented for X. X reported X. The X was described as X. The associated symptoms included X. X reported X for X. X continued to have X despite X. Examination of X revealed X consistent with previous X. There was X over the X at the X. X was X. X revealed X of X before X stopped it because of X, and X. X was X to the X. X and X were about X, but resulted in X. X was X. X to the X was X with X. There was X to X with X and X. On X, X visited X for a follow-up. X stated that X into X and X resulted in X for X. X might have X, but really X. Dr. X thought that based on X, X had symptoms since X and it was reasonable to consider X. X could likely X assuming X would respond X to this X. An X of X was performed on X for X, X, X, and X. There was no evidence of X. Treatment to date included X. Per a Utilization Review Decision letter dated X, the request for X was denied by X, MD. Rationale: "Per ODG, ODG Indications for X Criteria for X. Not recommended as X. (1) History: X. Treatment must be directed toward X. PLUS (3) Subjective Clinical Findings: X. AND X with X PLUS (4) Objective Clinical Findings: X. AND X AND X. PLUS (5) X. ODG Indications for X: Criteria for X with or without X require ALL of the following: (1) X. (2) Subjective Clinical Findings: Patient is X; AND has X. (3). Objective Clinical Findings: X AND / OR X. In this case, the X. X has been X. However, X showed X. Therefore, the request for X is not medically necessary." Per an Adverse Determination letter dated X, the X was X by X, MD. Rationale: "The X had a X. There is no evidence to support X. There is no documentation that the X. The X does not show evidence of X. The request is not medically necessary."

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

The ODG supports a X when X. The ODG supports X for X after a X. The ODG

supports X for documented X after X unless X are met. The ODG supports X. The X documentation provided indicates that the X. An examination documented X. Previous treatment included X. Additionally, the X is X. A X on X documented X and no evidence of X as well as X. There is a request for X. Based upon the documentation provided, a X would be supported as there is X. A X would not be supported as there is no documentation of X on any previous documentation that was provided. A X would not be supported as there is no evidence of X on X. A X would not be supported as there is no documentation of X.

As such, a X is recommended with X as medical necessity is established. However, noncertification is recommended for X as medical necessity is not established for this part of the procedure.

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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