

**IRO Express Inc.**

***Notice of Independent Review Decision***

Case Number: X

Date of Notice: X

---

**IRO Express Inc.**

**An Independent Review Organization**

**2131 N. Collins, #433409**

**Arlington, TX 76011**

**Phone: (682) 238-4976**

**Fax: (888) 519-5107**

**Email: @iroexpress.com**

***Notice of Independent Review Decision***

**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 is a X who sustained a X on X. On the date of injury, X was X. X was diagnosed with X. On X, X was evaluated by X, DO for X. X symptoms started from X where X was involved in a X. At the time, the X was X. X localized the X. The X consisted of X. X stated that if X, X had X. X denied X in X. Examination of the X revealed X. X was X with X and X. X was X. X of the X was X with X and X when X on X and X. An X was noted. Dr. X thought that X ongoing symptoms were X at X with X to X. A X of the X dated X revealed X. There was X and X. There was documentation of X at the X. The X was X. Treatment to date included X. Per an Adverse Determination

# IRO Express Inc.

## *Notice of Independent Review Decision*

Case Number: X

Date of Notice: X

---

letter dated X, the request for X was denied by X, MD. Rationale: "Regarding the request for X, the Official Disability Guidelines state that X is conditionally recommended as X for X. There should be X on examination. For a claimant with X there should be additional documentation of recent symptom X associated with a X that was X such as X. In the clinical record submitted for review, there was documentation of X that was X. However, there was a lack of documentation of X. The treating provider documented X. X was X, which would not warrant the request. In addition, in the request for authorization, there was a lack of documentation of the X. Therefore, the request for X is non-certified." Per a Utilization Review Decision letter dated X, the prior denial was upheld by X, MD. Rationale: "Spoke with Dr. X. A request is submitted for an X. The date of Injury is listed as X. A medical document dated X, indicated that X. There was documentation of X. It was documented that previous treatment X. Subjectively, X was described as X. Objectively, there was X. There was a documented diagnosis of X. It was documented that, a X accomplished on X, disclosed findings consistent with X. There was documentation of X. Based upon the medical documentation presently available for review, the above-noted reference would not support a medical necessity for this specific request as submitted. There is a lack of correlation with regard to documented X with X. Additionally, there is no documentation of a X upon a X based on X presently available for review. Based upon the medical documentation presently available for review, medical necessity for X not established."

### **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. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient's X to establish X. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

# IRO Express Inc.

## *Notice of Independent Review Decision*

Case Number: X

Date of Notice: X

---

### **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