# IRO Express Inc.

## *Notice of Independent Review Decision*

Case Number: Date of Notice:

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# IRO Express Inc.

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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

**INFORMATION PROVIDED TO THE IRO FOR REVIEW: X**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

**X** is a X who was injured on X. X sustained injuries to. X was a X who X was X. The diagnosis was X. On X, X was seen by X, MD. X presented in a follow-up and reported X. Pain was X. X also had X. X wanted X. X was a X. X requested an X. On examination, X had some X. The assessment included X. X does also have X. But that was not a X. X was recommended. X was prescribed. Per a report of X. DC on X, X was evaluated on X and had reached X. X had completed X. It was noted that X condition had X. Impairment of the X was based on X. There was history of X. There were no significant signs of X. X functions were X. Impairment of the X was based on history of injury and X. X was noted to be as follows :X X.X. An X was completed by X. X complained of X. X reported having X. X had increasing pain in the X. X was requesting a X. X did go to X. X had been told that X. The X had told X could not X. An X was considered but not authorized. X had a X. X had a X. X had received X. X had lost about X. X was being evaluated for X. X did have X. X pain was rated X. X reported symptom . On examination, X. X examination revealed X. X revealed X. The range of motion of the X. The range of motion of the X. The X. X revealed X. X showed X. Straight X, X. X testing revealed X. The assessment included X. On X, X was evaluated by X. X was in X. X had complaints of X. On examination, X had X. X. The assessment included X. X was to continue X. An X was completed. X were prescribed. An x-ray of the X dated X revealed X. An X dated X showed X. An X showed X. In the X, there was X. In the X. The study appeared to be X. There was X. Treatment to date included medications X. Per a utilization review adverse determination letter dated X by X, the request for MRI of X. Rationale: "This is a X who was injured on X when they were X. The claimant has been diagnosed with X. There are no documented X. X progress report from X, MD indicates that the claimant returns X. X pain has been X. The pain is in the X. The surgical history includes X. The current medication list includes X. On physical examination, there is X. The provider indicates X." "The clinical basis for denying these services or treatment: The ODG course X. The provided documentation indicates the claimant has X. There is objective X. The provider suspects X. It is unclear if there has been initial imaging with X. Based on the available information, X is not medically necessary. Recommend non-certification." Per an addendum dated X, the reviewer had spoken with Dr.X. The ODG course X when there is X. The provided documentation indicated X. There was objective X. The provider suspected X. During the peer-to-peer process, Dr. X indicated that X had X. As there was X. Per a reconsideration review adverse determination letter dated X by X, MD, X was not medically necessary or appropriate. Rationale: "ODG by MCG Evidenced Based Medical Treatment Guidelines,

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Section X. Conditionally Recommended CR Recommended as indicated below. X. X is recommended over "X. “X" X is experimental and therefore not recommended. ODG Criteria Indications for imaging – X): -X. This individual has complaints of X. It is unclear what treatment X. The working diagnosis is X, but the typical duration of a X X. This individual has had this pain for nearly 11 months, which would suggest tenosynovitis is less likely. Additionally, guidelines recommend X. As such, the medical necessity of the requested treatment is not established. The request for X is therefore not medically necessary or appropriate.”

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

The medical records were reviewed. In my opinion 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. There are limited objective findings documented on X. There is X submitted for review. The patient completed a X which indicates a finding that X. Per a report of X. DC on X, X was evaluated on X and had reached maximum medical improvement as of X. X had X. It was noted that X condition had X. Impairment of the X. X was noted to be as follows: 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