

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 who was injured on X. The X of the injury was X. The diagnosis was X. On X, X was evaluated X, MD for X. X rated pain at X. X stated X pain would increase to X with X. X had noticed X. X stated that the pain was X. X stated X felt the X. X reported the pain was X. The typical X. It was associated with X. X stated the pain would X. X score was X. X had X. It was opined that the X. The assessment was pain X. X was recommended. X was seen by Dr. X on X in a follow-up of X. X presented for follow-up

and re-assessment of the X. X rated the pain at X. X reported the X. It was X. X stated X was very X. The procedure which was initially performed in X had X. X reported the X. On examination, X. The X score was X. The X revealed X. X was noted on the X. There was evidence of X. Pain was noted X. There was X. There was X. An x-ray of the X dated X was reviewed, which showed X. The assessment was pain X. it was assessed that X had severe pain to the X. X had X. Dr. X believed X was caused by X. Therefore, because of the above findings, it was medically necessary to perform X. X planned on repeating this procedure, which in the past, had X. The X would also be contacted for X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, DO, the request for X. Rationale: "According to a X office note by Dr. X on X, there was documentation of the injured worker having X. There was also documentation of the injured worker having a X. There were X. There was also documentation of previous X. The treatment plan included to contact the X. The provider also reported that the injured worker has X. The provider also reported that the X. The provider also reported that a X. The provider also reported that a previous X. However, with no X, this would X. Also, according to the guideline criteria, X. Also, according to the guidelines, while X. Therefore, this request, the request for X." Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X. Rationale: "Evidence-based guidelines X. No X. Hence, this request X."

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

The request X. After thorough review of all documentation including X. Provider is requesting X. X, as exam X. However, this is a patient with X. X, in that X.

While patient's 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