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

Amendment X

IRO REVIEWER REPORT

Date: X; Amendment 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:

☐ Overturned Disagree

☐ Partially Overturned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who sustained an injury on X. The biomechanics of the injury is not included in the available medical records. The diagnoses included sacroiliitis, lumbar radiculopathy, and sacrococcygeal disorders. X was seen by X, DO / X, MD on X for initial evaluation and consultation for lumbar pain and sacroiliac (SI) pain. X described X pain as aching, shooting, stabbing, throbbing, and intermittent, and rated X. X reported pain that radiated SI joints and groin. The pain was progressively worsening since the X. X reported minimal relief with X ongoing X. X was status post right hip replacement on X and left hip replacement on X. X body mass index (BMI) was 34.5 kg/m^2. Lumbar spine examination revealed X. X had done X. There were lot of exercises which X could not do due to pain including using X bike and sit-to-stand was too much pain to participate in further physical therapy. It was noted that X was a good candidate for X. Treatment to date included X. Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “Official disability guidelines generally do X. While there are positive provocative maneuvers noted on the physical examination, guidelines do not support the requested treatment as there are no further definitive treatments that can be recommended based on the diagnostic information rendered from this procedure As such, the request is Not Medically Necessary or Appropriate. “Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “The Official Disability Guidelines do not support the practice of X. There are only potentially supported for inflammatory conditions such as rheumatoid arthritis or

ankylosing spondylitis. Guidelines indicate that no further definitive treatment can be recommended based upon their outcome. Furthermore, progress notes for this claimant dated X state that previous X have been provided, although their location is not stated. This request for X is noncertified. “Based on the submitted medical records, the requested X are not medically necessary or supported by the guidelines. While there are clinical findings suggestive of sacroilitis, there is no indication of an underlying inflammatory arthropathy. No new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified.

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

Based on the submitted medical records, the requested X are not medically necessary or supported by the guidelines. While there are clinical findings suggestive of sacroilitis, there is no indication of an underlying inflammatory arthropathy. No new information has been provided which would overturn the previous denials X is not medically necessary and non-certified.

Upheld

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE