

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:

- Overturned Disagree
- Partially Overturned Agree in part/Disagree in part
- Upheld Agree

IRO Express Inc.

Notice of Independent Review Decision

Case Number: X

Date of Notice: X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. The biomechanics of the injury is not available in the records. The diagnoses were other intervertebral disc displacement of lumbar region (X); intervertebral disc disorders with radiculopathy of lumbar region, radiculopathy of lumbar region and long term (current) use of opiate analgesic.

On X, X, MD evaluated X for a follow-up visit regarding low back pain radiating into left leg mostly. Condition was chronic and ongoing. Back pain was present and described as affecting the lower back and lower extremities. X was having a dull quality, radiating down into both lower extremities, being constantly present. X was unable to work and unable to carry out usual activities. The pain level at the time was X, at best X and at worst X. Opiate contract was reviewed. X reported full compliance with opiate contract. Prescription medications were used as prescribed without early refills. Prescription monitoring program was in place. X reported X. X reported that lying down, massage, and prescribed medications improved symptoms and activity, walking, exercise worsened symptoms. On examination, lumbar spine revealed X. X gait was antalgic. X had X. Urine drug screen dated X was consistent with the prescribed medications. X had reported improved functionality, quality of life, and analgesic control with X. Without these medications, X would likely suffer deterioration of functionality and worsening pain. X was under regular and random surveillance and risk assessment, except where otherwise noted.

Treatment to date included X.

Per a peer review and utilization review adverse determination letter dated X, the

IRO Express Inc.

Notice of Independent Review Decision

Case Number: X

Date of Notice: X

request for X was denied by X, MD. Rationale: "Based on the documentation provided, the ODG by MCG, Last review/update date: X, "X." On X, the patient sees Dr. X. There is low back pain that radiates into the left leg. Pain radiates into the right leg. The patient is utilizing medication. Lying down, massage, and medication are helpful. On exam, there is reduced lumbar range of motion. The plan is for ongoing care. In particular, clarification is needed on why X are needed. Therefore, the request for X is non-certified."

Per a peer review dated X and reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Per Official Disability Guidelines Knee and (Updated X), X." In this case, the patient has lower back pain irritating into the left leg. The pain was rated X. The examination revealed a X. However, there was no documented X. Therefore, this request is not medically necessary and is not certified."

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a peer review and utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Based on the documentation provided, the ODG by MCG, Last review/update date: X, "X are not satisfied." On X, the patient sees Dr. X. There is low back pain that radiates into the left leg. Pain radiates into the right leg. The patient is utilizing medication. Lying down, massage, and medication are helpful. On exam, there is X. The plan is for X. In particular, clarification is needed on why X are needed. Therefore, the request for X is non-certified." Per a peer review dated X and reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Per Official Disability Guidelines Knee and (Updated X), X, "X." In this case, the patient has lower back pain irritating into the left leg. The pain was rated X. The examination revealed a X. However, there was no documented X. Therefore, this request is not medically necessary and is not certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records X. The Official Disability Guidelines support the use of

IRO Express Inc.

Notice of Independent Review Decision

Case Number: X

Date of Notice: X

X. There is no documentation of X. There is no rationale provided to support the request outside guidelines. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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 clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a peer review and utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Based on the documentation provided, the ODG by MCG, Last review/update date: X, "X are not satisfied." On X, the patient sees Dr. X. There is low back pain that radiates into the left leg. Pain radiates into the right leg. The patient is utilizing medication. Lying down, massage, and medication are helpful. On exam, there is X. The plan is for X. In particular, clarification is needed on why X are needed. Therefore, the request for X is non-certified." Per a peer review dated X and reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Per Official Disability Guidelines Knee and (Updated X), X, "Recommended (generally) Recommended; may be a first-line option, ODG Criteria X may be indicated when ALL of the following are present : X." In this case, the patient has lower back pain irritating into the left leg. The pain was rated X. The examination revealed a X. However, there was no documented X. Therefore, this request is not medically necessary and is not certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records X. The Official Disability Guidelines support the use of X. There is no documentation of X. There is no rationale provided to support the request outside guidelines. Therefore, medical necessity is not established in accordance with current evidence based guidelines. X is not medically necessary and non-certified

IRO Express Inc.

Notice of Independent Review Decision

Case Number: X

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Upheld

IRO Express Inc.

Notice of Independent Review Decision

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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