

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

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

- X

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

X who was injured on X. The mechanism of injury was not documented in the available medical records. The diagnosis was strain of muscle, fascia and tendon at neck level, subsequent encounter; radiculopathy, cervical region; and chronic pain syndrome.

No office visits or imaging studies were provided for review.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Per ODG by X." Per ODG, "X in patient with good response to X, as indicated by X. Patient has had X. Procedure performed X." "Per ODG, "X." On X the claimant reported neck pain with bilateral upper extremity radiation, left greater than right. Prior treatment included a X on X with X relief for an unspecified duration of time. Pertinent medications include X. On physical examination, cervical range of motion was X. Spurling's test was X. The claimant was diagnosed with strain at the neck level. The treatment plan included a X. Prior treatment included X. In this case, cervical spine MRI revealed X. The claimant reported X. A call was placed to the office of X, MD X. A peer-to-peer call with X. It was explained that although X. However, X. The request is not shown to be medically necessary and is noncertified."

Per a peer review dated X, the appeal request for X was denied by X, MD. Rationale: "I am recommending non-certifying the request for APPEAL: X for the following reasons: The claimant was evaluated with reported neck pain with bilateral upper extremity radiation, left greater than right. On physical examination, cervical range of motion was X. Spurling's test was X. Prior report

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dated X, by X, MD, indicated the request for X was non-certified noting X. The submitted clinical records indicate that the claimant subjectively reported X pain relief for unknown duration following X. However, serial VAS scores were submitted for review which X. The claimant underwent X on X. The claimant reported X. X on X was rated at X, approximately X weeks following the X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.”

The request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “Per ODG by X. X.” Per ODG, “X.” “Per ODG, “X.” On X the claimant reported neck pain with bilateral upper extremity radiation, left greater than right. Prior treatment included a X on X. Pertinent medications include X. On physical examination, cervical range of motion was X. Spurling’s test was X. The claimant was diagnosed with strain at the neck level. The treatment plan included a X. Prior treatment included X. In this case, cervical spine MRI revealed X. The claimant reported X. A call was placed to the office of X. A peer-to-peer call X. It was explained that although X. However, X. The request is not shown to be medically necessary and is noncertified.” Per a peer review dated X, the appeal request for X was denied by X, MD. Rationale: “X recommending non-certifying the request for APPEAL: X: The claimant was evaluated with reported neck pain with bilateral upper extremity radiation, left greater than right. On physical examination, cervical range of motion was X. Spurling's test was X. Prior report dated X, by X, MD, indicated the request for X was non-certified noting monitored X, ODG by X. The submitted clinical records indicate that the claimant subjectively reported X. However, serial VAS scores were submitted for review which fail to corroborate subjective reports. The claimant underwent most recent X on X. The claimant reported X pain level of X on X. X pain level on X was rated at X, approximately X weeks following the X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.” There is insufficient information to support a change in determination, and the previous non-certifications are

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upheld. The Official Disability Guidelines require sustained improvement of pain or function of greater than or equal to X, as measured from baseline, for greater than or equal to X weeks after X. X note dated X notes pain level was X. This claimant received a X on X. The procedure note on this date indicates the claimant's reported pain level is X. Per note dated X, the claimant's reported average pain level was X with worst pain in the last week rated X. This was approximately X weeks following the X. Per note dated X, pain level was X. Given the lack of positive response to X, the request is recommended for non-certification. 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:**

The request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Per ODG by X. X performed at X." Per ODG, "X. Patient has had X. Procedure performed X." "Per ODG, "X is NOT recommended for any of the following...X." On X the claimant reported neck pain with bilateral upper extremity radiation, left greater than right. Prior treatment included a X on X with X relief for an unspecified duration of time. Pertinent medications include X. On physical examination, cervical range of motion was X. Spurling's test was X. The claimant was diagnosed with strain at the neck level. The treatment plan included X. Prior treatment included X. In this case, cervical spine MRI revealed X. The claimant reported X. A call was placed to the office of X, MD X. A peer-to-peer call with X, FNP {Nurse Practitioner) took place. It was explained that although X. The request is not shown to be medically necessary and is noncertified." Per a peer review dated X, the appeal request for X was denied by X, MD. Rationale: "I am recommending non-certifying the request for APPEAL: X for the following reasons: The claimant was evaluated with reported neck pain with bilateral upper extremity radiation, left greater than right. On physical examination, cervical range of motion was X. Spurling's test was X. Prior report dated X, by X, MD, indicated the request for X was non-

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certified noting X, ODG by X. The submitted clinical records indicate that the claimant subjectively reported X. However, serial VAS scores were submitted for review which X. The claimant underwent most recent X on X. The claimant reported X level of X on X. X pain level on X was rated at X, approximately X weeks following the X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The Official Disability Guidelines require sustained improvement of pain or function of greater than or equal to X, as measured from baseline, for greater than or equal to X weeks after X. X note dated X notes pain level was X. This claimant received a X on X. The procedure note on this date indicates the claimant’s reported pain level is X. Per note dated X, the claimant’s reported average pain level was X with worst pain in the last week rated X. This was approximately X weeks following the X. Per note dated X, pain level was X. Given the lack of positive response to X, the request is recommended for non-certification. X is not medically necessary and non-certified

Upheld

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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