

**Independent Resolutions Inc.**  
***Notice of Independent Review Decision***

Case Number:

Date of Notice: 7/26/2019 9:40:30 AM CST

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**Independent Resolutions Inc.**  
**An Independent Review Organization**  
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**INFORMATION PROVIDED TO THE IRO FOR REVIEW:** • Clinical Records –X

- Rush Peer Review–X
- Adverse Determination Letter –X
- Preauthorization Determination Letter –X
- Diagnostic Data –X

**PATIENT CLINICAL HISTORY [SUMMARY]:** X who had sustained a work-related injury on X. X stated X was approaching the X, X XX on a X. X was diagnosed with other X. X was seen by X, MD on X. On X, X presented for the evaluation of X X problems secondary to X injury on X. X had pain on the X and also the X. If X X quickly, X noted pain. X also noted a X, especially at the end of the day if X did a lot of activity. X had undergone X, which helped with X range of motion, but X continued to have X. The examination of the X degrees. There was X with X in the X consistent with a X problem. Further X did cause X pain. Moderate X was noted. The majority of the tenderness was noted along the X. X testing was positive for the X pain. This was reproducible and caused the majority of X symptoms. Radiographs of the X did not reveal any evidence of X orientation, no significant X, no evidence of X, no evidence of X, and no narrowing of the XX. Specifically, no X were noted in the X. Dr. X recommended X examination of the X with X. On, X X continued to have difficulty with X X symptoms with X. X noted pain especially if X ambulated and turned direction quickly. The physical examination essentially remained unchanged. An MRI of the X was performed on X, and revealed primary X greatest in the X; X; X; moderate X; and X-appearing X, most compatible with a X. The treatment to date included X, a X, and X(helpful). Per a utilization review

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decision letter dated X, the request of the X was denied by X, MD. Rationale: "The claimant has continued pain in the X. According to the guidelines, a X is recommended after failure of X treatment, which includes at least X months of X and X when there is evidence of X or X with the X. The MRI provided for review did reveal a X, greatest in the X. It was noted that the claimant was participating in X but there is no documentation of at least X-months-worth of involvement to include a X program. The request for X, X is not certified." Per an adverse determination letter dated X, the prior denial was X by X, MD. Rationale: "This X patient sustained an injury on X. The patient was X while at the same time sustained a X injury. The patient was diagnosed with pain in the X, and other X, current injury, initial encounter. In this case, the MRI of the X revealed primary X. Prior treatment included X and X, which helped with the X, but the patient continued to have X along with X. The patient had been utilizing a X. The patient underwent X repair dated X. Exam of the X revealed limited X consistent with X problem. There was moderate X. X testing was positive. The x-rays did not reveal any evidence of X orientation. There was no narrowing of X. Based on the foregoing, the patient's objective, subjective and diagnostic findings correlate with X. As such, medical necessity has been established based on ODG guideline support. As such, the requested X, X is medically necessary and is X."

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

The ODG supports X for X with ongoing X when there has been a failure of X care. Additional criteria are documented below. The documentation provided indicates that the injured worker has had X in the X since a X injury. Symptoms have persisted and have included X. A physical examination of the X documented an X, X, and positive X. Plain radiographs documented no X. An MRI of the X documented a X. Previous treatment has included X and X. The treating provider has requested a X. Based on the documentation provided, the ODG would support the requested X as the injured worker has ongoing X in the X which are X

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and have not improved despite X care. An MRI clearly documents a X and plain imaging documented no significant X.

As such, the requested X would be considered medically necessary and the request is 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
- TEXAS TACADA GUIDELINES

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TMF SCREENING CRITERIA MANUAL