Independent Resolutions Inc.

Notice of Independent Review Decision

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Independent Resolutions Inc.

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: Clinical Records –X
- Physical Therapy Notes –X
- Texas Workers' Compensation Work Status Reports –X
- Utilization Reviews –X
- Peer Review Reports –X
- Letter –X
- Diagnostic Data Reports –X

PATIENT CLINICAL HISTORY [SUMMARY]: X. X X is a X-year-old X who was injured on X. The mechanism of injury was detailed as X on X X X. X. X was evaluated by X, MD on X for X X pain, status post X, X/X, and X (X) at the X level. X continued to have pain in X X as well. X was X, but had pain and wished X had not had X surgery. On examination, mild X was noted. The X. There was X in the X. There was X, which contributed to the persistent pain. X had X test and equal X. X X was X and also X. There was X. The assessment included X, X and X X pain. An MRI of the X dated X showed a X with X, which extended slightly X of X. There was with, but X of the X. The treatment to date included medications (X), X, X, X, X program, X sessions, X, and X including X and X of the X X. Per a utilization review decision letter and a peer review dated X, the request for X for X times a week for X weeks, X visits was non-certified by X, MD. Rationale: "There is no detailed discussion of sustained X from a prior course of X. There is no discussion of a X program, no X Goals, no change in a therapy program. There is no clear clinical rationale for the need to exceed guidelines. The patient had 26 prior X. There is no documented X The patient's condition is now X, and the patient has already had excessive, X of similar X without documented sustained X and without new hard clinical indications for the need for additional X. Therefore, the request for X for the X, is not medically necessary." In a letter dated X, X, NP documented that X spoke with Dr. X in regard to denial of X and XX advised to resubmit the request for a reconsideration of X. Per an adverse determination letter dated X and a peer review dated X, the prior denial was upheld by X , MD. Rationale: "The claimant had had extensive prior treatment approved (X, per the claims administrator's referral form) i.e., treatment in excess of the X recommended in ODG's X Guidelines for X and X , i.e. the diagnoses reportedly presented here. The ODG further stipulates that the frequency of treatments should be appropriately tapered or faded over time, as claimant's transition to self-X. Here, the claimant' s already, lack of significant X impairment present on the date in question, commentary made by the attending provider to the effect that the claimant is already performing, taken together, effectively obviated the need for further formal X. Therefore, the request for X is not medically necessary."

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 recommended as medically necessary, and the previous denials are upheld. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient has completed approximately X. Additional supervised X would continue to exceed

guideline recommendations. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. The patient has completed sufficient formal X and should be capable of continuing to improve X with an independent, self-directed X program.
Therefore, medical necessity is not established in accordance with current evidence based guidelines and the decision is upheld.

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 X 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

☐ TMF SCREENING CRITERIA MANUAL