I-Resolutions Inc.
An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

X.

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified X

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

X

Patient Clinical History (Summary)

X who got injured on X, when X. X was diagnosed with X.

On X, X was seen by X, MD for X. X was X. It had been X. X pain level went X. X was found to have X. X continued X. X had X. X complained of more X. X examination showed X. There were two X. There was also a X. X was X. X was X. X reflexes were X. X of the X revealed X. X was added, X were continued, and X were recommended.

On X, X was seen by X for continued X. X was having X. X had X. The X. It was X. The examination was X. There were X. There was also a X. X was X. X was X. X were X. The X revealed X.

X-rays of the X dated X demonstrated X.X.

The treatment to date included X.

Per utilization review by X, MD on X; the request for X was not certified. The rationale: “This claimant has a X. X are reported to have provided X. There is X. Without evidence of X are not supported. This request is not medically necessary.”

Per reconsideration review by X MD X, the request for X was not recommended as medically necessary. Rationale: “This request is not medically necessary. There is X, and the previous non-certification is upheld. Note dated X, states that X has been X. X has had X. There is no information provided regarding the X. There are X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.”

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

This patient presents with a X. The patient has X. The provider has utilized X. The actual date of this X.” Two prior utilization reviews denied the request for a X. These reviews are correct in that the term “ X. The percentage X are required. Given the documentation available, the requested service(s) is considered not medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐
- ☐ DWC-Division of Workers Compensation Policies and 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 and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Medical Literature (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.