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An Independent Review Organization  
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**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 was injured on X. X and X. The diagnoses were X.

On X was X, NPC, DC. X had taken X. X rated the pain X. X of the X. X of the X. X present on the X. X was X. X showed X. X showed X. X of X. X was X. The plan was to X.

X x-rays X were X. X and X.

Treatment to date included X.

Per a Notice of Adverse Determination dated X was denied. Rationale: "A request is submitted for X. The date of injury is listed as X. A medical document dated X indicated X. There was documentation of X. There was documentation of X. A medical document dated X indicated that X. For the described medical situation, the medical necessity for this specific request

as submitted is not established. The above-noted reference does not support medical necessity for X. Consequently, presently, medical necessity for this specific request as submitted is not established. There is documentation to indicate that there has X. At present, the medical necessity for treatment in the X is not established. Recommend non-certification for X.”

On X, a Notice of Adverse Appeal Determination documented that the appeal for X was denied. Rationale: “The Official Disability Guidelines specify that patients should be X. A X is X. The guidelines specify that X is not recommended for X. The records indicated the parent had X. The X noted X. However, there was a X. There were X. In agreement with the X are 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. There is insufficient information to support a change in determination, and the previous non-certification is upheld. There is a lack of documentation of significant and sustained improvement as a result of treatment completed to date to establish efficacy of treatment and support additional sessions. Current evidence-based guidelines note that X is not recommended for X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

***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
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- 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)