Independent Resolutions Inc.
An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (682) 238-4977
Fax: (888) 299-0415
Email: @independentresolutions.com

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:

X

PATIENT CLINICAL HISTORY [SUMMARY]:
X who was injured on X when X. The diagnosis is X. X, DPM evaluated X on X for X. X presented for X. X complained of X. The X. It was X. X described the pain as X. It was X. On examination, the X. X revealed X. X was X. X was X. There was pain on X. X, was noted on the X. An MRI of the X. There was no MR evidence of X. Treatment to date included X. Per a utilization review adverse determination letter dated X, by X, MD, the request for X, was denied. Rationale: "Regarding the requested X, the Official Disability Guidelines indicate that a X. The records submitted for review indicated the request has been X. The records did not support that X. Therefore, the requested X is non-certified." Per a utilization review adverse determination letter dated X, by X, DPM, the prior denial was upheld with the following rationale: "In the clinical documentation submitted for review, there was no documentation of x-rays being performed since X. Therefore, the request for X is non-certified." The rationale was addended as follows: "Regarding the request for X, the Official Disability Guidelines state that for X. However, in the clinical documentation submitted for review, there was not documentation of X. Therefore, the request for X is 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. Per a utilization review adverse determination letter dated X, by X, MD, the request for X, was denied. Rationale: "Regarding the requested X, the Official Disability Guidelines indicate that a X is not routinely recommended and is X. The records submitted for review indicated the request has been made for a X. The records did not support that X. Therefore, the requested X is non-certified." Per a utilization review adverse determination letter dated X, by X, DPM, the prior denial was upheld with the following rationale: "In the clinical documentation submitted for review, there was X. Therefore, the request for X is non-certified." The rationale was addended as follows: "Regarding the request for X, the Official Disability Guidelines state that for X. However, in the clinical documentation submitted for review, there was not documentation of X. Therefore, the request for X is non-certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient has X. The X are not documented. It is unclear if there has been a significant change in the patient's clinical presentation to support updated imaging.
Therefore, medical necessity is not established in accordance with current evidence-based guidelines and the request 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 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

☐ TMF SCREENING CRITERIA MANUAL