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

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

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 while working as a X. X was X. The diagnoses were X. X on X. X required X. X had X. X aggravating factors included X. X was X. X was X. This had allowed X to X. X floor X. X. X. While X performed X. Also, X completed X. X. X. X. It was recommended that X continue X. The testing was conducted by X, DC. According to a X Report dated X, X attended X. X was able to X. During the X, X had been provided with X. On the X, X scored a X on the X Scale and a X on the X. On the X, X scored a X indicating a X. X reported being X. On the X, X scored a X, indicating X. X reported problems with the following: X. On the X, X scored a scored a X, which indicated a. X reported X. X reported often X. X attributed X X. X reported having X. The plan was to continue the X. An MRI of the X was performed on X. The study identified: X. The X was within X. There was X. There

was X. X demonstrated X. There was X. X demonstrated a X. There was X. X demonstrated X. There was X. X demonstrated X. There was X. X demonstrated X. There was X identified. Treatment to date included X. A Notification of Adverse Determination dated X stated that the initial request for X was denied. Primary Reason(s) for Determination: “Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, X. Treatment is not suggested for X. Total treatment duration should generally X. In this case, X was currently X. X attended X. X maintained X. X self-reported a pain score of X, which indicated a X. On the X scale, X scored an X, which indicated X experienced a X. On the revised X scored at X. On the X, X scored a X indicating a X. On the X, X scored a X, indicating X. On the X, X scored a X, which indicated a X. Overall, X had made X. The current treatment plan included an X. Given the presented X, the current request may be considered. However, the X. Guidelines require significant X. This lack of change in X. There ls X." In a Response to Denial Letter dated X, X, MS, LPC-S responded by stating: “As seen in all self-reported measures summarized, X. These are X. These goals are X. This program will emphasize the importance of X. The treatment plan will X. Lastly, it is evident that X continues to X. Our request is considered to be a medically appropriate treatment recommendation to proceed with an X.” On X, a Notification of Reconsideration of Adverse Determination denied the appeal request for X. Primary Reason(s) for Determination: “Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The patient's X to warrant the request. After reviewing the information provided, this request will be deemed as non-certified.”

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

Given the current clinical data, the request for X is recommended as medically necessary, and the previous denials are overturned. The patient has X. Current evidence-based guidelines would support up to X. When comparing the X. The patient’s X. The patient’s job X. The patient X. X. The patient was able to X. X Scale X. X decreased from X.

Given the patient’s progress in the program to date, the request for X is medically necessary for X. Therefore, the request is overturned.

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