I-Resolutions Inc.
An Independent Review Organization
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Patient Clinical History (Summary)

X who was diagnosed with X. The biomechanics of the injury was not available in the records.

On X, X was seen by X, NP-C for X pain. Location of the pain was in the X. The pain was X. Symptoms were aggravated by X. Symptoms were relieved by X. X suffered with X. X endorsed X with X ongoing X. X depicted pain in the X. X reported improved X. MRI of the X from X was reviewed, which showed X. At X was widely patent, however, there was X. Examination was consistent with X. X was X. X had pain in the X. On X, X was evaluated by X. The pain was X. The pain was aggravated by X. The pain was relieved by X. On examination, X was X.

Per a Peer Review by X plan, MD dated X, the requests for X were denied. “This treatment may be indicated in selected circumstances, where injured worker's symptoms, exam findings, and diagnostic studies correlate and confirm a X. The provided medical records, at this time, do not confirm such a X. Without further clarification or rationale, this request is not medically necessary at this time.”

Per a Peer Review by X, MD dated X, the request of X was denied. “This request was prior denied due to lack of X. There are no additional chart notes submitted verifying X, as evidenced by X. Overall, this request is not medically necessary.”

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

This patient presents with X. Two prior reviews have been completed, both of which denied the requested procedure. For an X, the ODG requires evidence of a X. Both are absent in this patient, as stated in the prior peer reviews. The ODG also requires radiologic or electrodiagnostic corroboration of the clinical findings. While the MRI did indicate X, the correlation with the clinical findings is X. 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.