**Independent Resolutions Inc.**
**An Independent Review Organization**
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**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 with date of X. X was X. X was X. The X which X stated X. X were X. Per a X, X documented that X was X, MD. Due to X reported X. X had X. X had X. It seemed like X. X had X. X had X. X had X. X had X with X and were X. X and X. X had a X. X was X. X was X and X. X or X. X was X. X and X. X was X. X got X. X was X. X used X before X would X. X used X. X to X. At X was X. X noted that X. X had X. X was X. X noted X. X needed to X. X demonstrated X. The X. X examination revealed X. X and X. X was X. X did X and X did X. X on X, by X, DC. Per the evaluation, X was X. X had X. However, X continued to X. X on the X. X in the X. Therefore, X must be X. On X, MD evaluated X for a follow-up for X. X did X. X appeal for continuation as denied. X had X. X did X. On examination, X was X. X and X were X. X was X. The X was X. X would X. Treatment to date consisted of X. Per a utilization review / adverse determination notice dated X, MD determined that the X was not medically necessary. Rationale: X. Diagnosis: X. Claimant was X. It appears claimant had X. X has X. X if claimant has X. X has X. Given the lack of sufficient clinical information to adequately review and support the request, request not medically necessary at this time. As such, the request for X is not appropriate." Per a utilization review

dated X, DC non-certified the request of X. Rationale: “In this case, the claimant was X. The X was denied. The provider indicates X is X. The guidelines available for X. Based on X. Therefore, this request for X is not medically necessary.”

**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 X to X in determination, and the previous non-certifications are upheld.
The submitted clinical records X. The submitted clinical records X. The submitted clinical records X and 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- 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