Independent Resolutions Inc.
An Independent Review Organization
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Notice of Independent Review Decision

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:
X, is a X who was injured on X. The mechanism of injury was not documented in the available records. The diagnosis was X, other X. On X, X was evaluated in a follow-up by X, PA for the X. The pain started X. It was located on X. The X. It X and was described as X. It was rated as X and X. It was X and X. On examination, X. Overall X was noted X. X in the X, X, X, X, X, and X. X showed X. X was X. The assessment was other X. X reported that X had significant benefit from X. X noticed X was X and do X and complete most of X. X stated X did not have X again after this, as X had to have X. It was noted that they would continue to X from X. Due to X, and X, they would schedule for a X at the X. Hopefully, this would give X significant X. Per a peer review dated X by X, MD, an MRI of the X showed X. X

studies performed by a X reportedly showed evidence of X. A X which was performed on X and X and X. Treatment to date included X and X, and X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "The ODG does not support the use of X. Per a reconsideration review adverse determination letter dated X, X, MD denied the request for X, as not medically necessary. Rationale: "Per ODG X guidelines regarding criteria for X, "X must be well documented, along with X findings on X. X must be corroborated by imaging studies and when appropriate, X, unless documented X. A request for X in a patient with X requires additional documentation of recent symptom X." A successful peer to peer has occurred. In the peer conversation, it was noted that the documented X, and in fact involves the X. It was reported that a X revealed X. However, on review of the X, there is no clear evidence of X. In this case, X. Therefore, the request for X is not medically necessary and the previous denial is upheld."

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-certifications are upheld. It appears that the patient is X. The Official Disability Guidelines note that X are not recommended. Additionally, there are no X submitted for review.

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