Independent Resolutions Inc.
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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 sustained X on X. The injury occurred when X was X and was in the X. X and X. X was diagnosed with X; X and X; X and X; X, X. On X, X was evaluated by X, MD in an office visit for X that was X, with X and X and X. The pain was X and X and X. The pain was made X and X, X, X and X. The pain did affect X. X included X. The X revealed an X, X and X. There was X. The remainder of the exam was X. The assessment included X and X. The treatment plan included an X due to X. An X dated X revealed X to be a X. X. X likely contacting the X in the X and X / X. X with a X / X the X and X. X with a X with X and X. X with X and X and X. Treatment to date included X, X, and X. Per Utilization review dated X by X, MD, the request for X of the X, as X and X be non-certified. Rationale: “Per ODG X guidelines regarding criteria for X, "X must be well documented, along with X on X. X must be

corroborated by imaging studies and when appropriate, X, X, X, and X support a X. A request for the procedure in a patient with X requires X. In this case, there is no documented evidence of X. X of the X, as X is X. Per reconsideration request dated X, X, MD denied the request for X of the X, as X and X. Rationale: "Understanding the date of injury, noting the X, given that the X did not identify any indications of a X, the X does not demonstrate any X, and as noted in the Official Disability Guidelines, these X are indicated for X. Furthermore, as noted with the previous not certification was X or X. Therefore, based on the clinical data presented for review and X noted in the ODG this is not recommended". In an X, Dr. X added "The claimant's pain complaints were X, with X. X and X were X. X was X. The X report dated X describes X, as well as X and X. X provide X, but this procedure is X. Given the X, and the X, a X.

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

X agree with the previous denials of this service. In particular, there is no documentation of objective X, or X complaints to consider a X. A request for the procedure in a patient with X requires additional documentation of recent X. As no X were noted in the X examination, medical necessity is not established in accordance with 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