**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, with a X and X on X and X and X. X was diagnosed with X. On X, X was evaluated by X, MD. X reported X that X following recent X. Examination of the X revealed a X, a X, a X, and X on X. Dr. X recommended X. On X, Dr. X noted X pain was rated at X and described as X, X, X, X, X, and X and X. Examination showed X, X, X and X, and X and X. X was diagnosed with a X. Other than the previously mentioned information, no additional clinical findings to support the need for this care were made available with this review. Dr. X was appealing the prior determination at this time. An X dated X identified X and X. X of the X and X was X. Treatment to date included X and X. Per Utilization Review dated X, the request for X under X between X and X was denied by X, MD. Rationale: “The Official Disability Guidelines stated X are not recommended,

including X and X / X. X are not recommended as there is X that can be recommended based on any diagnostic information potentially rendered (as X are not recommended for X). Consideration can be made if the X is required for one of the generally recommended indications for X. The authors indicated it was not clear if X of a X a X. The requested diagnostics, X is not supported at this time. In addition to the lack of guideline support, there does not appear to be any indication that X is being considered. Hence, the request for X is non-certified."
Per Appeal Review dated X, X, MD upheld the denied request for X between X and X. Rationale: "Regarding a X, the Official Disability Guideline (ODG) states it is not recommended. Regarding X, the ODG indicates X guided procedures in the X include X of X, X, X, X, and X. The X to X, X, and X can make use of X worthwhile for in-office image guidance. Based upon a review of the submitted records, the prior non-certification appears to have been appropriate. The guidelines do not support performing this type of X. Given there is insufficient scientific evidence and guideline support for this procedure for the treatment of X, the requested appeal for X is non-certified."

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**
X agree with the denial as evidence based guidelines do not support this procedure-X. Per ODG, X are not recommended as there is X that can be recommended based on any diagnostic information potentially rendered (as X are not recommended for X).
With no clear benefit in doing the procedure, medical necessity would not be established.

**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