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. X stated X was X. The diagnosis was X. X was seen by X, DO on X for X and X. X presented with X. X reported X were noted. X underwent X. Due to X, X was appropriately referred on X for X. X. X. X admitted to X. X was X suggestive of X. X was X. X intake X. X was on X per X family physician and X for this injury. Examination showed X at X. X had marked X with a X. X had X at the X with X. X were X. X throughout the X were noted. The diagnosis included X. X was recommended to avoid X. X at X was recommended. X had a follow-up with Dr. X on X for X ongoing complaints. X had X in the X that X, X, but now also X had a X on the X which was considered a X. A X was recommended. An X of the X dated X demonstrated X. X were X. X showed X. X revealed X. There was a X. A X include X. This finding on the X exam was X and X and would require a X.

Treatment to date included X. Per a utilization review adverse determination letter dated X and a peer review report by X, MD dated X, the request for X was non authorized as not medically necessary. The rationale given was as follows, "Official Disability Guidelines discusses X. An X may be indicated in an X to X. The medical records in this case do not clearly document symptoms, exam findings, and diagnostic studies which correlate at a particular X; rather the injured worker appears to have X. The guidelines generally would not anticipate meaningful or at least meaningfully prolonged benefit in this situation from an X. For these reasons, the request is not medically necessary and should be non-authorized." Per a reconsideration review adverse determination letter dated X and a peer review report dated X by X, MD, the request for X was non-authorized. The rationale given was as follows, "There is a request for X. The injured worker presents with X; however, X associated with X was 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:

The medical records and request was reviewed. The claimant has X. X was on X per X family physician and X for this injury. Examination showed X. X had marked X with a X on the X. X had X at the X with X. X were X. X were noted and X is documented. The records support X which has X. Reported symptoms are correlated with a X.

Based on the medical records provided, medical necessity is established for the request- X.

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