Applied Independent Review
An Independent Review Organization
P. O. Box 121144
Arlington, TX 76012
Email:@irosolutions.com
PH:(855)233-4304
FX:(817)349-2700

Notice of Independent Review Decision

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Description of the service or services in dispute:

X

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 with date of injury X. X was trying to X when X and X. The diagnosis was X.

On X, X presented to X, MD for evaluation of X. X reported feeling X and was unable to X. X had X in X. The pain was X. X had no X and X had been following the treatment plan and X. X had not had X. Pain was rated X. On examination, X was X and X was X. X was poor on X. X had X on the X. X had X pain on X. The assessment was X. Dr. X opined that there was no other treatment available for X. X had X and refused any kind of X and therefore X would possibly need X for X.

Per a progress summary dated X by X, PhD / X, MD, the pain resulting from X injury had X. X reported X and X related to the pain and X, in addition to X. Pain had resulted in X resulting in X. Per Dr. X / Dr. X, X would benefit from X. It would improve X ability to X. They opined that X should be treated X in X with X as well as X. The program was staffed with multidisciplinary professionals trained in treating X. The program consisted

of, but was not limited to X. These X services would address the X problems of X.

An MRI of the X dated X showed X. X caused X at X. X changes were seen at X. There was no X at X. The X was X.

Treatment to date included X.

Per a letter of adverse determination dated X, the request for X was non-certified. The clinical basis for denying these services or treatment was as follows: “Regarding X, the Official Disability Guidelines support X that X, and X. It is also intended to X. Objective testing X. Considering these objective findings and guideline recommendations, this request for X is not certified.” Per an addendum dated X, the provider making the determination spoke with X, who stated the X had not X. The Provider was seeking a X. X was not able to X, due to X. X rated X at X. X was X. X had reportedly X. X was X which would be X. Given X and modalities already completed, however, it was unclear how much the requested program would X. And without documentation of the program's outcomes, the request could not be supported.”

Per an appeal dated X by X, PhD / X, MD, the reviewer had denied X the X. X reported unsuccessful peer review, although X had been spoken to at length about X. X reported that X was able to X. X was X. X was initially denied based on X needed to X. X had completed X and X, but not X to X. Per Dr. X / Dr. X, the X would entail X which would help X become X. Additionally, the X would help X to X. X was deemed to be X and was X.

Per an appeal request denial letter dated X, the request for X did not meet medical necessity guidelines and was non-certified. The rationale was as follows: X. Therefore, the request for X is non-certified.”

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 recommended as medically necessary, and the previous denials are overturned. Treatment to date includes X. The patient has X. The patient’s X are X; however the patient does present with X. X indicates that X and required X is X for X. The patient’s employer does not X. The

patient is not a candidate for X. The patient is noted to be X. Therefore, the request is overturned and medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines European Guidelines for Management of Chronic Low Back Pain Internal 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 and Treatment Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters TMF Screening Criteria Manual

Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)

☐

☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)