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 with a date of injury X. The X of the injury was not included in the medical records. X was diagnosed with X with X, X; X; X; X with X; X or X without X; other symptoms referable to X; X; X, X; X. On X, X was evaluated by X, MD for X ongoing symptoms including X, X, and X. X had X for the X. X had a X on X and received X of X. On examination, X remained X in the X area X. There was a X, X than X. X of the X revealed X and X. X showed X in the X, X. It was hard to evaluate due to the fact that X had X on the X. There was some X in the X and X and X. X was X on the X and on the X producing X. X were X, which X. X, X, X, and X in the X in the X. X, X, X, and X were all X on X. X dated X revealed satisfactory X. appearing X without X or X. There was X and X in the X and X with X at X and X. The X likely X the X. Treatment to date included X, X, and X, X, X, X, and X including X, X, and X at X and X. Per a Utilization Review decision letter dated X, the request for X, as X was denied by X, MD. Rationale: “Recommended as indicated below for carefully

selected patients with proven X, following X. ‘Per ODG regarding X, no X should be X for at X and for X; X should not be used as X. a X during the procedure. X is required with documented X. In this case, the procedure note from the X show that X, an X was X. The X far exceeded the duration of X the X. On peer-to-peer, the treating physician reported that both X and X were X. In sum, the X does not meet criteria for X per ODG criteria. The request is not shown to be medically necessary”. In an appeal letter dated X, X, MD / X, PA documented that X had been followed for X, X, and X. X had X on X. This was also in addition to X and in X. X received X of X for X and then X stated after that it would X for X. More recently, X had X on X on X and X was rated at X with X. X request for X was denied. The reviewer felt that this rationale would not meet the criteria for a X even though it was done, and X received X. X commented that “X am appealing this adverse determination as the patient had X with the X and the X were X with almost X. Patient continued to get X and up to X. X pain has X, and X are X. Therefore repeating X on the X would be X and X and just X given by X”. Per reconsideration review dated X, the prior denial was upheld by X, MD. Rationale: “Based on the clinical information available for X review, the requested Reconsideration Review: X, as X is not appropriate as related to the X. Claimant is noted to have X showed X in the X. This is consistent with X. X is not supported. As such, this request is not medically necessary”.

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, 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. The submitted clinical records indicate that the patient presents with a X. This is a X to the requested procedure. Additionally, there is a lack of documentation regarding X.
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