I-Resolutions Inc.

An Independent Review Organization
3616 Far West Blvd Ste 117-501 IR
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 790-2280
Email: @i-resolutions.com

Notice of Independent Review Decision

Review Outcome

Description of the service or services in dispute:
X

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified 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 who sustained an injury on X. X, X. The diagnosis included X.

X was seen by X, MD on X for X. X sustained a work-related injury to X on X. X, X and X. X complained of X. X rated the pain X. X had X. X showed X. X test was X. There was X. X was X. X x-ray showed X. X were consistent with X.

An MRI of the X dated X demonstrated X. However, X in that region X evaluation. X were compatible with X. There were regions of X. X was noted.

Treatment to date included X.

Per a utilization review by X, MD on X, the request for X was non-certified. Rationale: “A peer review performed on X was noncertified the request for X. Additional records were submitted for review. The patient’s X is noted to be X which is within guidelines recommendations. However, the records also include an updated X MRI from X which revealed X compatible with X, without evidence of X. Furthermore, there were X. Additionally, although X noted X, this study did not note X. Based on these findings, a X is not supported. Therefore, my recommendation is to NON-CERTIFY the request for X.”

Per a utilization review by X, MD on X, the request for X was non-certified. Rationale: “The ODG by MCG recommends X for X. Almost half of patients with X possess X. X seem to determine X. The appeal X request in this case has been considered not medically necessary and, as such, this associated request cannot be substantiated. Additionally, this request has been previously

denied in peer review on X and it is no apparent that significant new information has been submitted to support this intervention outside the previous determination. The recommendation is for non-certification."

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The ODG recommends X in patient's with X. X is medically necessary and will X in the X, a X is supported. Based on the provided documentation, X is 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
- ☐ 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
- ☐ 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 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 Medical Literature (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

© CPC 2011 – 2017 All Rights Reserved