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

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 who was injured on X. X reported X injured X while at work X. The diagnoses included X. On X, X was seen by Dr. X for X follow-up of the X. X reported X had X. X had been X. X was a X. On examination, X. There was X noted over the X. X showed X. There was X. There was X. X was X. X revealed X. Previous X were reviewed and X. X dated X was reviewed. The assessment included X. It was noted that. X history, X, and X were consistent with a X. X was recommended X. X agreed as X needed a X. The X was scheduled on X, and X would X. X signed X. X was recommended to take X. X was recommended X. X was ordered. A X of the X dated X, demonstrated X. There was X. A X was noted with X. There was a X extending to the X. X was noted within the X. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X, by X, MD, the request for X. Rationale: “This injured employee has X. X examination shows X. X also shows significant X. X was also appreciated for X. However, a X is not supported as such a X. X as well as corresponding findings on examination and X. The request for a X. It is unclear X is requested for this X.

Guidelines only X. Without additional justification this request for a X. As no peer was established, this request is X. “Per a reconsideration review adverse determination letter dated X, by X, MD, the reconsideration request for X. Rationale: “Guidelines would X. There are complaints of continued X. Imaging studies also show X. However, guidelines would X. Accordingly, this request for X. Regarding a X. This request for a X.” The requested X. The medical literature does not support the requested X

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The requested X. The medical literature 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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**