

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:

- Overturned Disagree
- Partially Overturned Agree in part/Disagree in part
- Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X suddenly X. X was diagnosed with X. On X, X was seen by X, DO for a follow-up visit. X reported that X was X. X had X previously. Dr. X stated that X were noted. X had showed X. As a result, they were going to recommend X On X, X was seen by X, DO. Dr. X stated that X presented for follow-up visit regarding X. Again, jump signs were X. This X. X also had X. As a result, Dr.

X was going to recommend X. In the meantime, X affect continued to be X. They were going to X. X was X. Continued exercise, X were advised. X was X. X denied any side effects from X. X was X. X online X continued to X. X continued X was encouraged. An X dated X showed that there was a X. The X was slightly X; there was still contact of the X. A X had been performed at X. There was X. The X and X was seen at X Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The Official Disability Guidelines recommends X. The X is indicated for patients with well-documented X. This treatment should be X. This includes X. The guidelines also state that X. The guidelines X. Based on the submitted documentation, the request is not warranted. There is documentation of X. However, there is X. Additionally, although there is documentation of X. Therefore, the request for X is non-certified." Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The Official Disability Guidelines recommend X. A X is indicated when there is a X. The procedure is not recommended for X. X is required for X. Review X non-certified a similar request on X due to a X. They still needed a X, However, the X. As such, the prospective request for X is non-certified. Thoroughly reviewed supplied documentation including progress notes, peer reviews. Patient with X. Had successful X. On second review, peer reviewer noted this X. This was due to the guidelines they utilized (ODG). However, based on medical evidence, best practices, and provider's other documentation, X. Patient's care should X. Further patient has documented X. X request for X is medically necessary and certified

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

Thoroughly reviewed supplied documentation including progress notes, peer reviews. Patient with X. Had successful X. On second review, peer reviewer noted this benefit but also noted there X. This was due to the guidelines they utilized (ODG). However, based on medical evidence, best practices, and provider's other documentation, X. Patient's care should X. Further patient has documented X is medically necessary and certified

Overtured

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