Independent Resolutions Inc.
An Independent Review Organization
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Notice of Independent Review Decision

Amended Letter X; Amended X

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 who was injured on X. X was X. X. The diagnosis was X. On X, X was seen by X, MD for a follow-up of X. X reported X. X had X and X. X was going to X. X felt X was making some X. The X was X. X was working on X. On examination, X were noted. X was noted. There was X. X was X. X was X. There was X and X. The X was X with X to X. X and X were X. X was X. It was opined that X would allow X to reach X. X re-evaluation was performed by X, X on X. X reported X continued to see X in X and X. X stated X had X. X rated X but that could X to X with activity. X stated X was X. X reported X was able to X but was unable to X. X continued to present with X in X. On examination, X revealed X and X. X in X. X had difficulty X, X. It was opined that X would benefit from X. An X of the X on X showed X. X of the X on X showed no evidence of X. Treatment to date included X. Per a utilization review

dated X by X, MD, the request for X were noncertified. The rationale included, "The X is a X who sustained an injury on X. The X was approved for X; it is unclear how many X to date the X has X. The X is noted to be X with a X. Further, the requested X for the X to include X is non-certified. "Per a utilization review dated X by X, MD, the request for X to include CPT codes X were noncertified. The rationale included, "The X is a X who sustained an injury on X. The X had completed X. The requested X is not medically necessary. The X has already completed X and should be X in a X. There appeared to be no extenuating circumstances that would supersede the recommended guidelines. Therefore, the requested 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 not recommended as medically necessary. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient has completed X to date. The request for X would exceed guidelines. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. The patient has completed X and should be capable of continuing to X and X with X.

Given the documentation available, the requested service(s) is considered not medically necessary.

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