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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:

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who sustained X injury on X. X stated that while X was X. The diagnoses included X. On X, X was evaluated by X, MD for X. Following the X and X, X was taken to the X (X) and was X. X went to X and was given X. X went to the X and stated X was X. X was not sent for X. X was given X. X stated X told them that X would report them to the state if X did not have more X and X, X then saw Dr. X that worked X up and X recommended X (X). The X examination findings showed X. The X and X was X. There was no X. X had X to X. X, X, X were X. The X was X. X and X were X. X, X, X, X, X, X, X, X, and X were all X. X was X. The assessment was X. Dr. X opined X would be a candidate for X. On X, X was evaluated by X, MD for X. X has had been seen by Dr. X who recommended X (X). There was no indication

for X. X was to have X, however, the request for X was denied. X continued complaining of X. X would contest the decision. X earlier X reports were reviewed. X had X with Dr. X. X examination revealed X. The plan was to have a precertification for X. The X dated X revealed X. An X of the X dated X, revealed there was X. On X an X of the X revealed X. Treatment to date included X. Per a utilization review adverse determination letter dated X, by X MD, the request for X was non-certified. The rationale was as follows: "The official disability guidelines only support a X for individuals who have X and corresponding X symptoms of a bothersome X. This X does not complain of any X, X, X, or X to X current symptoms to any X. Regarding X, this procedure is only supported if an X is noted on X, and none is present. It is also unclear what type of X is being requested. As such, this request for X is not supported." Per a utilization review adverse determination letter dated X, by X, MD, the request for X was non-certified. The rationale was as follows: "The Official Disability Guidelines state that X is indicated when there has been X, X, X, and X. The guidelines also recommend X for X. The claimant complained of issues with the X and was previously treated with X. An X of the X dated X, revealed X. X was present. There was X. X which could be due to X or X was noted. However, there was a lack of recent examination findings to support the X. As such, the request for X is non-certified."

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

The ODG recommends X when there has been X of X with X and X in the setting of X. The ODG recommends X when there has been X of conservative care with X and X. The ODG recommends X when there is a failure of X with X or X. The ODG recommends X when there is a X with X as well as X are X, at least X, at X, and X on X. The ODG recommends X when there is X that has X. The documentation provided indicates the X has X. On X, there is X. An X has shown X. Given the duration of symptoms, X symptoms that include X are supported. As there is definitive X on X that corroborates the clinical findings, there is no support for X in addition to the X. As there are no clinical or X of X is not supported. Given the evidence of X, the request for possible X is appropriate to X and X depending on the X findings.

As such, the recommendation is to partially overturn the prior denials with

certification of X and noncertification of 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
- 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