**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:

X

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

X

**PATIENT CLINICAL HISTORY [SUMMARY]:**
X is a X who was injured on X. X at the X. X was seen initially at X. X was then seen in the X. X was on X when that happened so it was a Worker's Compensation injury. X with X. X had X. The diagnoses were X. On X, X underwent X. The X diagnosis was X. This procedure was performed by X. On X, X was evaluated by X for X done on X. X was X. X was X from X injury at the time. X was doing better. X was X. X was working on X. X had been using the X. X was working X. X was having X requiring X. X scale was X. On examination, X had X. X had some X and X of X. X had X. X had X. X was X. The assessment was X. X was recommended to start X and proceed with X. X demonstrated X. At this point, X stated that X would start X. X would need to X. X did have X. X would need X. X was X so X stated that he thought X can proceed with X. There was no need for X. It was fine for X to be X

but X should limit X. X was recommended a follow up in X for X. X underwent X from X through X and X through X. Per X daily treatment note dated X, X evaluated X and documented X was X after X last time. X stated that X did take X at the time of visit which hopefully would help. X continued to display X. X had some X in X after X at the time of visit; however, still X and X and X. X continued to be X in X and ideally the addition of further X work would help facilitate X. X continued to have X intervention due to X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, the request for X for the X was denied. Rationale: "In this case, claimant has X and X. X has had X with X still at X. X would be in excess of the guidelines. The patient should transition into X. Therefore, X is not medically necessary." Per a reconsideration / utilization review adverse determination letter dated X by X, the request for X was denied. Rationale "Per Official Disability Guidelines, "Allow for fading of treatment frequency (from X to X, plus X. X: X treatment: X." Based on the provided documentation, the claimant presented for a follow-up of X. On examination, there was X and X but this does cause X. X is X. X has X in X and X. It was noted the claimant has completed their approved X. X is excessive in nature. There is no significant evidence provided for review that would indicate the claimant cannot address any current and/or remaining X with transitioning to X. Therefore, medical necessity has not been established."

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

The ODG supports X for the X. The documentation provided indicates that the X underwent X and X for X on X. The X has attended X, and the most recent evaluation documented X in X with X. The provider recommended X. When noting that the current request exceeds guidelines and there is no indication if X has been efficacious or that the worker cannot X, additional treatment would not be supported.

Therefore, X is not supported as 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