I
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

IRO REVIEWER REPORT

Date: X

IRO CASE #: 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:

☐ Overturned Disagree

☐ Partially Overtuned Agree in part/Disagree in part

☒ Upheld Agree

.

I

INFORMATION PROVIDED TO THE IRO FOR REVIEW: ● X

PATIENT CLINICAL HISTORY [SUMMARY]: X is a X who was injured on X. The mechanism of injury was not available in the provided medical records. The diagnosis was low back pain and cervicalgia. Please note that office visits, current imaging, and treatment to date were not available in the provided medical records. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale for denial of X: “Per ODG X, "X must be well documented, along with X. X must be corroborated by imaging studies and when appropriate, electrodiagnostic testing, unless documented pain, reflex loss, and myotomal weakness abnormalities support a dermatomal radiculopathy diagnosis. A request for the procedure in a patient with X." In this case, there is no documented evidence of X. There is also no mention of X. X is not shown to be medically necessary. Therefore, the requested X is denied.” Rationale for denial of X: “Per ODG, " X. X X. A request for a procedure in a patient with X." In this case, there is no documented evidence of X. There is no record of X. X is not shown to be medically necessary. Therefore, the requested X is denied.” Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X was denied. Rationale for denial of X: “Per The ODG by MCG, X. In this case, there is X. Furthermore, guidelines do not generally recommend X except in the presence of X. As such, the appeal request for a X is non-certified.” Rationale for denial of X: “Per The ODG by MCG, X. In this case, it was noted that the claimant had X percent improvement in X. However, there is no documentation of how long the pain relief and improved function lasted. There are also X. Furthermore, guidelines do not generally recommend X except in the presence of X. As such, the appeal request for a X is non-certified.” Thoroughly reviewed provided documentation. No documentation provided from clinical records that corresponds to radicular symptoms affecting lower extremities to warrant X. While there was some benefit from X. X is not medically necessary and non certified

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

I

Thoroughly reviewed provided documentation. No documentation provided from clinical records that corresponds to radicular symptoms affecting lower extremities to warrant X. While there was some benefit from prior X. X is not medically necessary and non certified
Upheld

I

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**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**