Independent Resolutions Inc.
An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (682) 238-4977
Fax: (888) 299-0415
Email: @independentresolutions.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 Overturned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who sustained an injury on X. X reported that a X. X ended up helping to X. The diagnoses included concussion without loss of consciousness, sprain of ligaments of cervical spine, and contusion of unspecified front wall of thorax. X was seen by X, PA on X for a follow-up of concussion, neck strain, and thorax contusion. X had been attended X. X complained of X. X had a history of X. X was scheduled for X. On examination, X stuttering in speech fluency and trouble findings words had improved since the prior visit. X appeared in X. X was X. Neck range of motion was reduced with flexion and extension X degrees, right lateral flexion X degrees, left lateral flexion X degrees, right lateral rotation X degrees, left lateral rotation X degrees. Neck movement was limited due to pain. X had neck stiffness. X was X. Mini-mental state examination revealed X. X was very X. X was unable to maintain X. Ankle over tibia test was X. Left foot twitching was uncontrollably with performing test; missed toe on the first tap and hit it on the second attempt. X was noted in left foot. An MRI of the brain on X was X. An MRI of the cervical spine on the same date revealed X. Treatment to date included X. Per the Adverse Determination by X, MD on X, the request for X was non-certified. Rationale: “ODG by MCG states " X. Patient ambulates X feet with supervision Day Treatment: o Total treatment duration should generally range up to X months; o If treatment duration in excess of X months is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided; o Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility;o At the conclusion and

subsequently, re-enrollment in repetition of the same or similar rehabilitation program only if medically warranted for the same condition or injury or exacerbation of injury; o Suggestions for treatment post-program should be well documented and provided to the referral physician; the patient may require time-limited, less intensive post-treatment with the program itself; o Defined goals for these interventions and planned duration should be specified. o For individual outpatient therapies, see specific entries in ODG." In this case, the patient has the subjective complaints of X. The patient is recommended for X to improve function and decrease pain. However, there is limited documentation provided to support the X or the need for X. Medical necessity has not been met. As such, the request for X is not certified. Per the Physician Advisor Determination on X by X, DO, the request for X was non-certified. Rationale: “After reviewing the records provided, there is no indication that the claimant needs X. There are limited objective findings of impairment documented. Given that, the request is not medically necessary. “In review of the clinical findings, there were insufficient clinical findings consistent with a X. The claimant’s MRI report findings were X. The records did X. Therefore, it is this reviewer’s opinion that medical necessity is not established for the requested 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:

In review of the clinical findings, there were insufficient clinical findings consistent with a X. The claimant’s MRI report findings were X. The records did X. Therefore, it is this reviewer’s opinion that medical necessity is not established for the requested X. X is not medically necessary and non certified.

Upheld

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