

**Independent Resolutions Inc.  
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***Notice of Independent Review Decision  
Amendment X***

**IRO REVIEWER REPORT**

**Date:**X; Amendment 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 was injured on X. Per a utilization review adverse determination letter dated X, the request for X that was received on X was denied by X, DO. Rationale: "The proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. Per the ODG by X X is recommended. X and X are considered X. There is insufficient evidence to support the safety and effectiveness of X for any indication. The claimant had ongoing right X. However, X is not supported by the guidelines as it is considered X. As such, the request for X is not medically necessary. Per a reconsideration review adverse determination letter dated X, the request for X that was non-authorized on X was denied by X, MD. Rationale: "The proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. Official Disability Guidelines does not recommend X. On X, claimant has X. X - the claimant X. Although claimant has X. As such, the request for X is non-certified." Thoroughly reviewed provided documentation including provider notes and peer reviews. Patient remains with significant X. As patient has X. There is sufficient evidence to support use of X. However, patient does meet patient X is medically necessary and certified

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

Patient remains with X. As patient has X. There is sufficient evidence to

support use of interventions such as X. However, patient does meet X is medically necessary and certified  
Overturned

**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