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 was injured on X, while X. The diagnoses included X. X was seen by X, MD on X for complaints X. X examination indicated X. X loading was X. X was X. X was noted in the X. X prescribed X and placed a request for X.X of the X completed on X noted X.An X of the X completed on X noted X. There was X. Treatment to date included X, which had helped.Per a utilization review adverse determination letter dated X by X, MD, the request for X DOS: X was denied. Rationale: "the proposed treatment consisting of X: X is not medically necessary for this diagnosis and clinical findings. The Official Disability Guidelines state that X are indicated for a X. X at a level X are the only recommended approach; X are not recommended. This treatment should be administered in X. X should require documentation that X. Based upon the medical documentation presently available for review, the above-noted reference does not support a medical necessity for this specific request. X should require documentation that X. There is no documentation of a X. Given the clinical findings on examination,X: X is not medically necessary."A clinical note dated X by X, MD reported that X had complaints of X. It was reported that X. Ongoing medications included X. X examination noted X. Treatment plan included X.Per a reconsideration review dated X by X, MD, the denial for X: X was upheld. Rationale: "The proposed treatment consisting of X: X is not appropriate and medically necessary for this diagnosis and clinical findings. Official Disability Guidelines recommends X. In this case, there is a lack of documentation of X. There is also a lack of findings on X. As such, the request for X: X is non-certified.Thoroughly reviewed supplied documentation including X.Patient with X. Examination shows some X. There may also be X per examiner documentation. Combination of X. Provider does not explain X. Requested X is not warranted.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:

Patient with X. Examination shows X. There may also be some X. Combination of X. Provider does not explain X. Requested X is not warranted. X: X is not medically necessary and non certified

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