

**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 is a X-year-X who was injured on X. The mechanism of injury was not available in the provided medical records. The diagnoses were low back pain and sprain of ligaments of lumbar spine.

No office visit or latest imaging was available in the provided medical records.

Treatment to date included X.

Per a Utilization Review Adverse Determination Letter / Peer Review Report dated X by X, MD, the request for X was denied. Rationale: "ODG by X. ODG Criteria X." In this case, there is no record of X. Recently updated ODG criteria now X. The request is not shown to be medically necessary. Therefore, the request for X is non-certified."

Per a Reconsideration Review Adverse Determination Letter dated X and a Peer Review Report dated X by X, DO, the request for X was denied as not medically necessary. Rationale: "Based on the documentation provided and per the ODG guidelines, the requested procedure is not recommended at this time. Though the claimant has a history of chronic low back pain, there was no documentation of the claimant having X. Additionally, there were no findings on imaging to support the procedure. Therefore, the request for X is not medically necessary."

Thoroughly reviewed provided records including provider notes and peer reviews.

Patient with X. Cited ODG criteria used to X. Thus, request for 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:**

Thoroughly reviewed provided records including provider notes and peer reviews.

Patient with X. Cited ODG criteria used to X. Thus, request for 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:**

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- TMF SCREENING CRITERIA MANUAL
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- MILLIMAN CARE GUIDELINES
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- INTERQUAL CRITERIA
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE