

I-Resolutions Inc.

***Notice of Independent Review Decision***

I-Resolutions Inc.

**An Independent Review Organization**

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***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)

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Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

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#### **INFORMATION PROVIDED TO THE IRO FOR REVIEW: · X**

**PATIENT CLINICAL HISTORY [SUMMARY]:** Patient Clinical History (Summary)X is a X who was injured on X. The mechanism of injury was described as a motor vehicle accident. The diagnosis was injury of left anterior cruciate ligament and acute internal derangement of left knee. Please note, no records were available in the provided medical records other than 2 utilization reviews. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “No, the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. The Official Disability Guidelines recommend X. The claimant was complaining of left knee pain. Objective findings were X. The claimant has a history of X. However, the surgery was X years ago and the claimant must had postoperative therapy prior to this request. The claimant must have known how to do home exercises to address tenderness. Also, the claimant do have full range of motion and strength. Hence, the medical necessity of the requested X has not been established. Thus, the request for X is noncertified. “Per a reconsideration review adverse determination letter dated X by X, DO, the request for RECON X was denied. Rationale: “No, the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. The Official Disability Guidelines conditionally recommend therapeutic exercise for knee conditions when there is functional deficit noted. On X, the claimant was seen for an office visit and reported pain in the left knee at X with hyperextending sensation that occurred occasionally. The claimant is X on X. The

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claimant had X. On the exam, the left knee had trace effusion. There was medial and lateral joint line tenderness. The surgical wound was healed. There was full flexion and extension. All ligaments appeared stable. There was a X. This request was previously reviewed and denied as the surgery was X years ago in X and the claimant must have had X to this request. The claimant must have known how to do home exercises to address tenderness. Also, the claimant had full range of motion and strength. This review pertains to the request for X. In this case, the claimant had X and there is no documentation for the number of sessions completed and their response. There is no documentation for functional impairment noted. Also, an X exceed the guideline recommendation. Partial certification is not permitted in this jurisdiction without peer-to-peer discussion and agreement. As such, the request for X is noncertified. Based on the submitted documentation, the requested X is not medically necessary. No records have been submitted which would overturn the previous utilization reviews. The utilization reviews provided are appropriate do not establish that X is indicated. 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:**

Based on the submitted documentation, the requested X is not medically necessary. No records have been submitted which would overturn the previous utilization reviews. The utilization reviews provided are appropriate do not establish that X is indicated. X is not medically necessary and non-certified

Upheld

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**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)**

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**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**