

**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***  
***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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**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- X

**PATIENT CLINICAL HISTORY [SUMMARY]:**

X who was injured on X. The mechanism of injury was not available in the provided medical records. The diagnosis was low back pain and post-laminectomy syndrome.

On X, X, MD, evaluated and treated X for low back pain described as constant and burning, worsened by walking activity and better with medications and rest. The pain was rated X without pain medication. X denied any side effects with medication use. On examination, X was ambulating normally, and tandem gait test was normal. Musculoskeletal system examination showed joints, bones, and muscles with no contractures, malalignment, tenderness, or bony abnormalities and normal movement of all extremities. Extremities revealed no cyanosis, edema, varicosities, or palpable cord. Lumbar spine showed normal extension, negative straight-leg raising test, and no paravertebral tenderness. Normal thoracolumbar curvature was noted. Dr. X recommended X. The assessment was low back pain and post-laminectomy syndrome. X were prescribed.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "The requested service(s) or treatment(s) are not medically necessary or appropriate and are therefore not approved. In this case, there is no evidence of objective functional benefit associated with the prior use of the medication. In addition, there is no updated and signed pain contract, risk assessment profile, and recent urine drug screening. ODG states that X. It is

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indicated for X. Patient is determined to be suitable candidate for X. Prescriber certifies presence in medical record of X. Initial course, as indicated by all of the following: active treatment plan is in place, as indicated by X. Subsequent course, as indicated by all of the following: X. Urine toxicology scheduled testing for adherence performed. Prescription is for X. In this case, there is no evidence of objective functional benefit associated with the prior use of the medication. In addition, there is X. As such, the medical necessity of this request is not established. Therefore, the requested X is not medically necessary. This medication does not necessitate weaning.” X is medically necessary and certified.

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

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “The requested service(s) or treatment(s) are not medically necessary or appropriate and are therefore not approved. In this case, there is no evidence of X. In addition, there is X. ODG states that X. It is indicated for X. Patient is determined to be X. Prescriber certifies presence in medical record of X. Subsequent course, as indicated by all of the following: active treatment plan is in place, as indicated by X. Prescription is for X. In this case, there is no evidence of X. In addition, there is X. As such, the medical necessity of this request is not established. Therefore, the requested X is not medically necessary. This medication does not necessitate weaning.” X is medically necessary and certified.

Overtured

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**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