

Independent Resolutions Inc.
An Independent Review Organization
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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

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X, when X. The diagnosis was oromandibular dystonia and allergic rhinitis.

On X, X visited X, MD for a follow-up evaluation of a problem located in the jaw and moderate-to-severe in severity. X stated X wanted to discuss alternatives about X due to insurance denying. X had been experiencing pain mostly on X right side that felt like a “crunch.” X was also having headaches, jaw pain when eating, or even talking. X stated X had helped X A comprehensive otolaryngologic examination was performed and X. The assessment was X. Dr. X noted that X had significant jaw pain, discomfort, and mastication dysfunction associated with this as well as X. X had X. Unfortunately, this helpful therapeutic intervention had been denied. Dr. X did review the denial letter dated X at that point and noted that they did miss their window to appeal directly with the carrier and at that point would proceed with an independent review organization in attempts to provide X. X had experienced functional improvement following X. It was a well-established treatment for X.

An MRI of the brain from X was X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “ODG by MCG Last review/update date: X: X
"Not Recommended (generally)NR Not recommended as a first-line option;

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evidence shows inconclusive benefit, lack of benefit, or potential harm. ODG X is NOT recommended for any of the following: X The patient has a history of a X which occurred on or about X. The patient underwent magnetic resonance imaging on X, which was X. The patient has previously been diagnosed with X and has been treated with X on X. Per ODG, "X is NOT recommended for any of the following: X." The request exceeds the guidelines. Therefore, the request for X is non-certified."

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: ""ODG by MCG Last review/update date: X: X Not Recommended (generally)-NR Not recommended as a first-line option; evidence shows inconclusive benefit, lack of benefit, or potential harm. ODG X is NOT recommended for any of the following: X A successful peer-to-peer call with X, PA, was made. The details of the request were discussed, and the results of that discussion are documented below. The patient is a X on X. The patient has a history of a X on X. The patient has been seen as being evaluated and treated for X. The treatment consists of X. A discussion occurred regarding the fact that this treatment is not approved. The patient will be reassessed and evaluated for X. Therefore, the request for X is non-certified."

In a letter dated X, X, MD wrote regarding the medical necessity appeal for X for X. The X had been denied. X had suffered a X. X had previously undergone X on X and again on X, both of which provided substantial, documented relief from the debilitating symptoms directly attributable to the work-related injury. Based on this established therapeutic success, the ongoing denial stating that treatment was "not medically necessary" was medically unsound and inconsistent with the principles of evidence-based care and patient-specific functional outcomes. Dr. X provided the following clinical justification: X continued to experience refractory jaw pain and muscular spasms localized to the site of trauma. Conservative modalities such as X. X functional improvement following X was significant, including reduced pain scores, improved mastication, and resolution of involuntary muscle tightness. X is a well-established treatment X. This treatment

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was not experimental or cosmetic; it was a targeted, effective, and minimally invasive intervention that had demonstrably improved X ability to function and perform daily tasks-goals that aligned squarely with the mission of the Texas Workers' Compensation system. In conclusion, Dr. X wrote, "The denial of this treatment is, respectfully, inappropriate, unsupported by the medical facts of this case, and detrimental to the patient's recovery. I request an immediate reversal of the denial and authorization for the X."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD, as not medically necessary. Rationale: "ODG by MCG Last review/update date: X: X a, X: X is a form of X. While X. This review aims to provide a framework for practical clinical approaches, beginning with the recognition of clinical subtypes of X. Careful stepwise planning is recommended to identify the X. It is the authors' intention for this review article to be a foundation for X. X. Even though X is still not officially approved by the US Food and Drug Administration for X, it is recommended as the first-line therapy by most experts and evidence-based literature. However, this chapter highlights the need for further controlled studies of X. Treating physicians should be diligent when evaluating patients with X, performing careful clinical observation and examination as well as evaluating functional interferences X. Once a patient's candidacy for X is established, careful stepwise planning should begin by selecting the X. As muscles involved in X are small, delicate, and situated in closed proximity, adverse events due to X spreading may occur and close follow-up visits are advisable, especially for the first X. Patients should be involved in outcome selections and priority should be given to outcomes that are directly related to disturbed daily functions. Future studies in X should aim to harmonize candidate selections, X protocols and outcome assessments to deliver robust efficacy to gain therapeutic approval for this much needed disorder." A previous utilization review dated X was non-certified on the basis of "A successful peer-to-peer call with X, PA, was made. The details of the request were discussed, and the results of that discussion are documented below. The patient is a X on X. The patient has a history of a X on X. The patient has been seen as being evaluated and treated

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for X. The treatment consists of X. A discussion occurred regarding the fact that this treatment is not approved. The patient will be reassessed and evaluated for X. Therefore, the request for X is non-certified." X is not listed as an approved indication for X. There is also limited clinical documentation provided about the use of X. There is only one statement that the patient had X prior, but no comment on the X. A successful peer-to-peer call with X, PA, was made. The details of the request were discussed. The provider reported understanding, based on prior peer-to-peer (P2P), that this indication was not an approved indication and that the medication was no longer needed. Therefore, the request for X is upheld and non-certified."

X is an accepted treatment for X which is a supported diagnosis based on review of the clinical findings. Every X for this type of treatment. Therefore, it is this reviewer's opinion that the service in dispute X is medically necessary and the previous denials are overturned. X is medically necessary and certified

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

X is an accepted treatment for X which is a supported diagnosis based on review of the clinical findings. X for this type of treatment. Therefore, it is this reviewer's opinion that the service in dispute X is medically necessary and the previous denials are overturned. 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