

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X whose X.

X was seen by X, DDS on X. X stated "X." On examination, there was generalized X. X-rays and clinical examination were completed, and treatment was indicated. X was reported. Decay / X present on X. Deep X were noted on posterior teeth. The X was medically necessary, recommended line of treatment was presented to the patient in order to prevent X. The diagnosis was generalized moderate chronic periodontitis. Due to X. There was X.

Treatment to date included X.

Per a utilization review determination letter dated X; the request for X date of service X is denied. Rationale: "The clinical basis for denying these services or treatment: Benefits are only allowed if there is X. The X has not been demonstrated. The screening criteria or guidelines that we used to make the decision, which are the X."

Dr. X completed an appeal letter on X. Previous denial had been reviewed. It was their understanding that X. The claimant experienced symptoms X. Without physically examining the patient, they felt that X. The denial of this claim should be reversed immediately.

Per an adverse decision letter dated X, the request for X, is denied. Rationale: "The clinical basis for denying these services or treatment: Benefits are X. The X has not been demonstrated. The screening criteria or guidelines that we used to make the decision, which are the X."

Per a utilization review decision letter dated X, the request for X is denied. Rationale: "The clinical basis for denying these services or treatment: Benefits are X. The X has not been demonstrated. The screening criteria or guidelines that we used to make the decision, which are the X."

This case involves a X who is appealing the X. The initial review denied benefits due to lack of X. A review of the radiographs show early X. There is adequate documentation and evidence to support the necessity for X. I recommend the denial is overturned. X is medically necessary and certified

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

This case involves a X who is appealing the denial of X. The initial review denied benefits due X. A review of the X. There is adequate documentation and evidence to support the necessity for X. I recommend the denial is overturned. X is medically necessary and certified
Overturned

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